1. Description of the SNP Population:

Element A: Description of the Overall SNP Population

Optima Health is uniquely positioned to provide care to the Managed Long Term Services and Support Program (MLTSS) dual eligible population given our long-term experience with Medicaid, the Aged, Blind and Disabled (ABD) population, and Elderly or Disabled with Consumer Direction (EDCD) participants through the Medallion 4.0 and 3.0 programs and Medicare Advantage. We have been successfully administering a Medicaid health plan in the Commonwealth of Virginia since 1996 and our current Medicare Advantage plan since 2014. We have served members within both plans who have been eligible for Medicare and Medicaid and have witnessed firsthand the unique characteristics of the dual population – ranging in scope from highly complex medical and behavioral health conditions to serious social-economic needs.

In 2016, the Virginia Department of Medical Assistance Services (DMAS) issued a RFP for a MLTSS program. The three primary program tenets are:

1. an integrated delivery model for medical, behavioral and long term services and supports
2. care coordination and
3. person centered care through an interdisciplinary approach.

Optima Health was selected as one of six health plans to provide statewide coverage to this long term care population.

DMAS defined the eligible MLTSS categories as Qualified Medicare Beneficiary Plus (QMB Extended Coverage), and other Full Benefit Dual Eligible (FBDE). Currently Optima Health serves almost 15,000 dual eligible members in the MLTSS population. Of that number, some 750 are enrolled in Optima Community Complete (HMO D-SNP).

To enhance the coordination and integration of the MLTSS dual eligible population, DMAS has required MLTSS health plans to secure a Dual Eligible Special Need Plans (D-SNP) contract with CMS for coverage in each of the six DMAS regions across the Commonwealth of Virginia. The D-SNP plan is available to Medicare beneficiaries (Parts A, B and D) and any of the other designated Medicaid eligibility categories.

Optima Health brings our experience, knowledge and resources to the MLTSS dual eligible population as an integrated care delivery system. In addition, Optima Health will draw on the experiences and expertise of its sister organizations, Sentara PACE and Sentara Lifecare Nursing Homes to administer Institutional and Community-based Long Term Services and Supports.

- Clear documentation of how the health plan staff determines or will determine, verify, and track eligibility of SNP beneficiaries.

Identification of D-SNP eligible beneficiaries

The initial eligibility determination is based on the DMAS 834 enrollment file and verified through the CMS MARx system to ascertain full Medicare coverage. D-SNP members are identified through various mechanisms, including but not limited to:

- DMAS eligibility files, noting the eligibility status qualifying the member for D-SNP and to which D-SNP the member belongs
- Initial Welcome Calls and Health Risk Assessment/Health Risk Screening activities
  - Coordination of Benefits (COB) questions are asked
  - Confirmation of Medicaid eligibility through review of DMAS issued documentation, as well as Medicare ID Cards.
- Ongoing claims and eligibility data queries and exchanges in the CMS TROOP system
- Care Coordination processes, including but not limited to discharge planning, transitions program support, assessments, individualized care plan (ICP) development, and authorizations
  - Self-reported by member
  - Reported by care/service providers

DSNP eligibility is verified through ongoing file data exchanges and updates. Claims are matched through the CMS TROOP system, to assure appropriate payment levels are applied, but also as a resource to verify eligibility for Medicare Programs. During each member interaction, the member's coverage status is verified through member attestation. Eligibility files are updated several times a month, when new data is refreshed from DMAS, and eligibility history is retained in the information system, to facilitate claims payment and COB activities.

Because a D-SNP member's eligibility for enrollment is based on his/her dual coverage through both Medicare and Medicaid, D-SNP coverage can be lost or interrupted at times. Medicaid eligibility is subject to change due to variation in the member's income from one month to another, change in the State's criteria for eligibility, delays in submitting financial verifications, or another change in status. This may cause a dual eligible member of a D-SNP to become ineligible for the plan, due to the loss of his/her Medicaid eligibility for a period of time that may be one or more months in duration.

If Optima Health has no reasonable expectation that a member, who has lost his/her special needs status, will regain that status within a short period (not to exceed three months), the member will be dis-enrolled from the SNP in accordance with guidance in Chapter 2 of the Medicare Managed Care Manual.

Alternatively, Optima Health will retain the member, deeming him/her eligible if the expected period of loss of eligibility is three months or less, per Chapter 2 of the Medicare Managed Care Manual.

- A detailed profile of the medical, social, cognitive, environmental, living conditions, and co-morbidities associated with the SNP population in the plan's geographic service area.

Target Population Detail

Based on our experience with dual members in our Medicare Advantage and Medicaid health plans, this population can be best characterized as high need/high cost. A general demographic profile would be low income, elderly, female, frail with profound socio-economic issues and serious/complex medical and behavioral conditions. These medical and behavioral conditions include multiple co-morbidities, complex chronic conditions, depressive disorders and dementia.

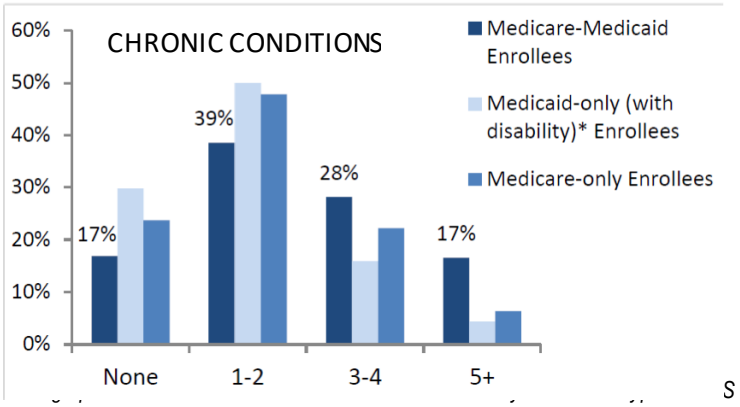
Snapshot of the Special Needs Population:

- *Average age 70 and older*
- *68% female*
- *Multiple chronic co-morbidities greater than five*
- *An average of over six medications*
- *Assistance required with two or more activities of daily living*
- *Almost half have dementia*
- *30% have major depressive disorders*
- *15% have protein-calorie malnutrition*

It has been our experience that unaligned dual eligible beneficiaries have faced a multitude of barriers and challenges in accessing Medicare and Medicaid benefits and services. These members experienced difficulties in navigating through the two programs. This fragmented delivery system approach has resulted in higher ED visits, inpatient hospitalization admissions/re-admissions and poly-pharmacy for this population. Higher utilization translates to higher costs.

CMS and DMAS demographic, utilization and cost data on the Virginia dual population generally reflects the Optima Health experience.

The majority of the target MLTSS dual population have chronic conditions; many with multiple, co-occurring. This is illustrated in the Medicare-Medicaid Enrollee Information report from the Center for Medicare and Medicaid Services (CMS) 2009 state specific report.[1]



Medicaid enrollees in Virginia.

[1] Centers for Medicare and Medicaid Services. Medicare-Medicaid Enrollee State Profile 2009 -Virginia. Page 2, Figure 4. 3 Ibid. Page 5, Figure 7. A presentation by the DMAS highlighted the top 5 primary diagnoses by medical setting.

Out of the 24 chronic conditions CMS studied, 84 percent of the dual-eligible enrollees had one or more chronic condition and 45 percent had three or more chronic conditions.

Recent studies have focused attention on the challenges to Medicaid, Medicare and the Duals programs resulting from the high prevalence of individuals with co-morbidity. Among individuals with a mental/cognitive condition, approximately 20 percent have more than one condition. Several studies have documented the implications of multiple co-morbidities for poor health outcomes such as risks of disability and increased costs of care. Co-morbidity of physical and behavioral health conditions increases care complexity and poses additional problems in coordination and access to needed services.

The CMS study also identified a prevalence of chronic medical conditions among the dual eligible population in Virginia. The top 11 chronic conditions identified were as follows, in descending order:

1. Diabetes
2. Depression
3. Heart Disease
4. Congestive Heart Failure
5. Arthritis
6. Alzheimer's Disease and Dementia
7. Chronic Obstructive Pulmonary Disease
8. Chronic Kidney Disease
9. Osteoporosis
10. Stroke
11. Cancer

Utilization

Dual eligible beneficiaries use services more than beneficiaries with Medicare who do not have Medicaid, as depicted in the table below:

SERVICES	THE PERCENTAGES OF FULL-BENEFIT DUAL ELIGIBLE MEMBERS	FOR MEDICARE BENEFICIARIES WITHOUT MEDICAID
Physician Services Utilization	88%	75%
Prescription Drugs Utilization	87%	30%
Outpatient Hospital Utilization	73%	56%
Emergency Room Utilization	45%	22%
Inpatient Hospital Utilization	26%	14%

Cost of Care

The combined Medicare and Medicaid spending for a full-benefit dual eligible was $2,479. Of this, the Medicare program spent $1,323 and the Medicaid program spent $1,156. The largest components of Medicare spending were inpatient hospitalization

(29%), outpatient hospital (11%), and Part D drugs (24%). The largest components of Medicaid spending were for institutional long-term care (56%) and community-based long-term care (31%).

Demographics

The following table illustrates the demographic information for the dual eligible population in Virginia:

Age		Race	
Under 65	(41%)	White	(56%)
65-74	(22%)	Black	(36%)
75-84	(22%	Asian	(6%)
Over 85	(15%)	Other	(2%)

According to the Kaiser Family Foundation, characteristics of the population include multiple chronic conditions, with physical and mental disabilities, in general poor health (www.kff.org Publication #8138-02). Healthcare service utilization is high in this population as a result of the complex medical and behavioral conditions. They are more likely to use the Emergency Department (ED) and also more likely to have multiple ED visits in the course of a year. They are twice as likely as the general Medicare population to have multiple inpatient stays.

- Identification and description of the health conditions impacting SNP beneficiaries, including specific information about other characteristics that affect health such as, population demographics (e.g. average age, gender, ethnicity, and potential health disparities associated with specific groups such as: language barriers, deficits in health literacy, poor socioeconomic status, cultural beliefs/barriers, caregiver considerations, other).
  - Define unique characteristics for the SNP population served:
  - D-SNP: What are the unique health needs for beneficiaries enrolled in a D-SNP? Include limitations and barriers that pose potential challenges for these D-SNP beneficiaries.

Unique Characteristics

Based on the demographic information and utilization data, the dual eligible population in Virginia represents the most vulnerable and neediest. From a medical perspective, the high incidence of co-morbidities, behavioral health, complex chronic conditions and poly-pharmacy warrants the need for enhanced care coordination. The assigned care manager ensures that the members with co-morbidities or complex chronic conditions have direct access to appropriate specialists, members with behavioral health needs are assigned to integrated medical groups for primary care services and medicine reconciliation is provided to members with poly-pharmacy.

The social-economic and environmental conditions of the population also have a direct effect on their health status and must be identified and addressed as an integral part of the individual care plan as discussed later in the application. Some of the most prominent factors involve transportation, health literacy, socialization, residential setting, language, cultural differences, daily living activities, substance abuse, language qualifications, nutrition, care giving and other support services.

Optima Health recognizes the critical need to identify these factors for each MLTSS dual member during the initial assessment and develop an individual care plan that is tailored to meet those specific needs. This may include referrals to community programs and resources for services not covered by Medicaid or Medicare such as meals on wheels or subsidized housing.

Enhanced coordination also entails member education on Medicare and Medicaid benefits and how to best access services whether aligned or unaligned with the Optima Health D-SNP. The care manager assists the member in navigating between Medicare and Medicaid in a manner as seamless as possible.

Regional and Geographical Differences

As mentioned earlier, Optima Health is currently providing MLTSS services throughout the six DMAS regions. The table below displays the total MLTSS enrollment by eligibility type.

REGION	DUALS WITH & WITHOUT LTSS	MEDICAID-ONLY WITH LTSS	NON-DUALS & NON-LTSS (ABAD)	TOTAL BY REGION
Central	28,081	4,848	21,539	54,468
Charlottesville/Western	16,429	2,481	10,733	29,643
Northern/Winchester	22,808	4,972	10,345	38,125
Roanoke/Alleghany	13,978	1,911	9,677	25,566
Southwest	11,616	853	9,320	21,789
Tidewater	21,209	3,851	18,095	43,155
TOTAL	**114,121**	**19,121**	**79,504**	**212,746**

Optima Health understands both the challenges in providing services to the MLTSS dual members and the opportunities for improving the provision of services to this population. Through our years of experience serving the Medicaid ABAD population statewide, we fully comprehend the geographic barriers and regional differences that exist. For example, the Appalachian Mountains create a geographic barrier that isolates residents of the region from the rest of the state. Provider density is proportionally lower in certain regions. Another example can be found in southwest Virginia where there is a shortage of health care professionals, making the delivery of health care services a challenge. Availability of important long-term services and supports, such as Adult Day Health Centers and Home Health Agencies are also limited in certain areas of the Commonwealth. Transportation to available services takes longer as a result of the mountainous terrain and weaker transportation system infrastructure.

The health and wellbeing of Virginians is not consistent across the Commonwealth, often as a result of economic challenges. Regional variances exist in the rate and types of disease states as well as levels of unhealthy behaviors. For example, the southwest region has a higher rate of disease and unhealthy behaviors as a result of the economic challenges of the region. Residents experience a higher prevalence of lung cancer, asthma, and diabetes as well as the adverse effects resulting from substance abuse. Studies have shown the impact of prescription medications, specifically opioids, in the number of deaths that occurred in western Virginia.

Optima Health also recognizes the significant racial disparities that are concentrated in metropolitan areas (Northern Virginia, Richmond, Virginia Beach) and Southside Virginia. The Virginia Department of Health's 2012 Health Equity Report and the updated version of the Virginia Health Opportunity Index identify several key factors that are associated with health inequities in Virginia. Poverty, limited education attainment, socioeconomic status, built environment, and place of residence are some of the more significant factors that create disparities in health status.

Individuals with Chronic or Disabling Conditions, the Medically Most Vulnerable

The target population includes individuals with specific chronic illnesses. More than half of all dual-eligible individuals have three or more chronic conditions as compared to non-dual eligible, and 50 percent (50%) also have a cognitive or mental impairment versus non-dual eligible. A larger share of dual-eligible individuals need help with activities of daily living, such as dressing or feeding. General and health literacy are also a significant challenge. Language and general ability to communicate due to language, speech, visual and hearing deficits further complicate the needs of the most vulnerable populations. Cultural norms, poor socioeconomic status and caregiver limitations are all impactful considerations as well.

Optima Health recognizes the following sixteen (16) conditions to be the most prevalent among the targeted population (not listed in order of prevalence). This population can be classified as special needs, requiring more care interventions.

1. Chronic alcohol and other drug dependence;
2. Autoimmune disorders (including, but not limited to, polyarthritis, polymyalgiarheumatica, polymyositis, and Rheumatoid arthritis);
3. Systemic lupus (erythematosus-culled out as a category from autoimmune, due to prevalence);
4. Cancer excluding pre-cancer conditions or in-situ status;
5. Cardiovascular disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorder);
6. Chronic heart failure;
7. Dementia;

8. Diabetes mellitus;
9. End-stage renal disease requiring dialysis;
10. Severe hematologic disorders (aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease excluding sickle-cell trait, and chronic venous thromboembolic disorder);
11. HIV/AIDS;
12. Chronic lung disorders, such as Asthma (chronic bronchitis, emphysema, pulmonary fibrosis, and pulmonary hypertension);
13. Chronic and disabling mental health conditions (bipolar disorders, major-depressive disorders, paranoid disorders, schizophrenia, and schizoaffective disorder);
14. Neurologic disorders (amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis – hemiplegia, quadriplegia, paraplegia, monoplegia, and Huntington's disease);
15. Multiple sclerosis, Parkinson's disease, polyneuropathy, spinal stenosis, stroke-related neurologic deficit; and
16. Stroke.

An analysis of the aged, blind, and disabled (ABD) and Acute and Long-Term Care (ALTC) individuals enrolled in the Optima Health Medicaid managed care plan prior to moving to Optima Health Community Care MLTSS program confirms that these diagnoses are among the highest cost. The top four diagnoses that drive 20 percent (20%) of the total expenditures are cardiac and cardiovascular disease, end stage renal disease, sickle cell, and diabetes. Unfortunately, it is often the underlying chronic conditions, such as diabetes or sickle cell that drive the cost and utilization up more. Pharmacy costs among the ABD populations are eight times higher than the remaining Medicaid Temporary Assistance to Needy Families (TANF) population. The higher pharmacy cost is attributable to the increased utilization of mental health medications, in particular antipsychotic drugs.

The Optima Health ABD and ALTC findings are consistent with an analysis of dual-eligible and long-term care claims data from Virginia Medicaid; however, among the Virginia Medicaid population, mental and behavioral health disease is the second most prevalent diagnosis in terms of utilization and cost. In its Blueprint of the Integration of ALTC presentation, DMAS states that 30 percent (30%) of the population in Virginia account for 70 percent (70%) of the total Medicaid expenditures, which is why there is a fiscal imperative to manage care and cost. Today, per capita spending in Virginia on the ABD in an institution is twice that for someone living in the community.

The complexity of social and health care needs expands in the age 65 and older population, as the population grows in number and in age over the next decade. Individuals age 65 and older are less likely to drive and twice as likely to be disabled. Their multiple chronic medical and behavioral health conditions are exacerbated by the socio-economic issues they face. The Congressional Budget Office report projects that the U.S. population of age 65 and older will have a 1.1 percent (1.1%) decline in health status until 2040. The report also found that educational impairment is often an

important predictor of disability.

The fact that the Virginia population is aging is compounded by the reality that the need for long-term care services will outstrip Virginia's capacity, which creates more support for a D-SNP program to divert citizens from institutionalization. Virginia has slightly more than 35 nursing home beds per 1,000 patients, compared to a national average of 48 beds per 1,000, and the number of Virginia nursing homes that accepts Medicaid recipients is declining, as well. This skilled nursing-bed shortage in the long term further supports the need to develop alternative-care systems for the most medically needy in Virginia.

Dual-Eligible Population Goals

Care goals for this population include:

- aggressive and comprehensive coordination of benefits, providers, and management to improve quality of care;
- fostering relationships between the patient and the primary care provider;
- identification of member preference, as well as, social, emotional, financial, medical, and behavioral health needs contributing to the attainment of self-maintenance goals and community residence; and
- identification of services and resources acceptable to the member to facilitate optimal care.

Optima Health focuses its efforts on identification of the medically underserved, low-income, and rural residents, and those community partners who are already supporting them, or who can expand services to meet the population needs. Service provisions include care coordination, pharmacy management and medication reconciliation, advanced illness care and advanced care planning, benefits coordination, and enhanced mental health services and coordination as well as a specialty provider network. In addition, Optima Health has a strong recognized background in chronic disease management with programs that routinely identify, stratify, and offer medically evidence-based services to our members.

Element B: Sub-Population: Most Vulnerable Beneficiaries

As a SNP, you must include a complete description of the specially tailored services for beneficiaries considered especially vulnerable using specific terms and details (e.g., members with multiple hospital admissions within three months, "medication spending above $4,000"). The description must differentiate between the general SNP population and that of the most vulnerable members, as well as detail additional benefits above and beyond those available to general SNP members.

Assumptions

Assumptions related to condition prevalence and eligibility for case management services are consistent with NCQA Special Needs Plan Structure and Process Measures. Optima Health uses claims, lab pharmacy, hospital discharge, utilization management, as well as provider and caregiver data to analyze the health status of the population. In addition, Optima Health utilizes current hospital and emergency room admission data to track member utilization real time and to increase the timeliness of interventions and follow-up with these members. All individuals are enrolled and maintained in an opt-out care coordination program. The Optima Health program includes a comprehensive health risk assessment, determination of available resources and benefits, coordination with the member's Medicaid or Medicare plan for unaligned members, development and implementation of an individualized care plan (ICP) complete with performance goals, monitoring, and follow-up plans.

Comprehensive Risk Assessment

All enrolled members are assessed using a variety of assessment instruments administered by the Care Coordination specialist. The assessment process focuses on identifying the member's medical, psychosocial, cognitive, functional and environmental needs. Health Risk Assessments (HRAs) provide detailed information about the member's health status and needs across physical, behavioral, social, functional, cognitive, LTSS, wellness, and preventive domains. As part of the HRA, the Care Coordinator also captures information about the member's Primary Care Provider (PCP), specialists, and other current service providers, such as those providing Waiver or other LTSS services. This data is used to identify additional vulnerable populations such as individuals with cognitive or memory problems.

- A description of the internal health plan procedures for identifying the most vulnerable beneficiaries within the SNP.

Identification of Subpopulation Vulnerable Members

Subpopulation identification is an ongoing process. Changes may occur that impact the member's subpopulation classification.

Analyzing claims, diagnosis codes, and other logic, members are stratified into subpopulations. For example, an EDCD Waiver member may suffer a stroke, which could result in the member moving from the EDCD Waiver subpopulation into the institutionalized/nursing facility subpopulation. Identification of a member's subpopulation category is stored in Symphony, our care management system. Care

Coordinators work closely with Optima Health Enrollment specialists to update the member's eligibility category with DMAS and our Symphony subpopulation category based upon changes (impacting the population categorization) in the member's status, condition, living situation, or changes in the member service plan.

- A description of the relationship between the demographic characteristics of the most vulnerable beneficiaries with their unique clinical requirements. Explain in detail how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status and other factor(s) affect the health outcomes of the most vulnerable beneficiaries.

Vulnerable Subpopulation Characteristics

Additionally, individuals in these sub-populations are considered to be most vulnerable or at an even greater risk if they are age 65 and older, poor, frail, disabled, chronically ill with multiple conditions, typically taking multiple prescription and over-the-counter medications, and/or nearing end of life. These individuals are the greatest risk for becoming institutionalized and many are of low general and health literacy and may not speak English. The complex nature of their health, intellect, and mental acuity add greatly to their risk.

Sub-Populations of the Target Populations

In addition to the above target populations, there are specific sub-populations that exist with each of the identified target populations. Some sub-populations may be represented in more than one of these defined target populations. The following paragraphs describe the Optima Health understanding of the various sub-populations.

a. The Commonwealth of Virginia has included the individuals enrolled in the EDCD as the target population. The EDCD waiver, with its population transitioning into MLTSS managed by MCOs beginning in August 2017, provides services in the community for individuals who are elderly or have a disability. Such individuals must meet nursing facility level-of-care criteria. The EDCD waiver includes other Home and Community-Based Waiver (HCBS) individuals, some of whom have intellectual and developmental disabilities. EDCD waiver services include personal care (consumer and agency directed); respite care (consumer and agency directed); private duty nursing; adult day care; personal emergency response system (PERS); medication monitoring; environmental modifications; assistive technology; and transition coordination and transition services; from long term care institutional settings back into the community. Up to a third of these individuals have a severe mental illness and major depressive disorders and may also suffer from multiple medical conditions. This population is also 8 -10 times more likely than the general Medicaid population to have high poly-pharmacy utilization.

b. Another waiver available to Virginia residents is the DD/ID Waiver directed at individuals with intellectual/developmental disabilities. Optima Health Community Care covers the medical and behavioral health services for this population, while

their waiver services remain covered under fee for service Medicaid. Generally, these individuals have a third to fifth grade reading level. This tends to be the primary impediment of this population, and statistics support that these individuals are three times more likely to have less than a high school education. As a result, individuals with intellectual/developmental disabilities are unable to comprehend simple clinical instructions and information, and generally require third-party oversight or a caregiver to aid with activities of daily living. This population is also at risk for increased medical utilization.

Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury) are unable to recall or retain simple instructions. Like individuals in other SNPs, these individuals require third-party oversight or a caregiver to aid with activities of daily living and are also at risk for increased medical utilization and concerns regarding safety are real. These members and their caregivers can benefit from waiver services such as adult day, personal care and respite services, as well as services aimed at increasing safety and decreasing elopement opportunities.

c. Individuals with physical or sensory disabilities require the use of equipment and/or other aids in order to accomplish activities of daily living. This population requires assistance from wheel chairs, prosthetics, walkers, hospital beds, and other durable medical equipment or assistive technology. It is very likely that the majority of the individuals in this population will require third-party oversight or a caregiver to aid with activities of daily living and to assure member safety, and are at an increased risk for increased medical utilization.

d. Individuals residing in nursing facilities include those with no willing or able caregiver to support them in the home environment. These individuals, like other special needs populations, require a third-party oversight or a caregiver to aid with activities of daily living and are at risk for increased medical utilization. Among duals living in facilities, statistics support that they were likely to have been admitted to the hospital at least once, which is twice the rate of duals living in the community. Among nursing home patients that receive mental or behavioral health medications, about 46 percent (46%) take antidepressants, 27 percent (27%) take antipsychotic drugs, and 64 percent (64%) are prescribed psychoactive medications.

e. Individuals with serious and persistent mental illnesses are individuals most frequently diagnosed or suffer from bi-polar disorder, schizophrenia, major depressive disorder, or other psychoses, which impairs their ability for self-care. Many of these individuals have co-morbid medical conditions and often times

require a third party oversight or a caregiver to aid with activities of daily living. Like other SNPs, individuals with serious and persistent mental illness are at risk for increased medical utilization.

f. Cerebral, vascular, and renal disease are the top three diagnoses in the dual-eligible population and are the common conditions that effect individuals with complex or multiple chronic conditions. Individuals with these diseases have other complicating factors such as diabetes and cardiovascular disease, hypertension and cardiovascular disease, or heart failure and chronic obstructive pulmonary disease (COPD). Individuals in this SNP are at risk for increased medical utilization due to poly-pharmacy and multiple providers.

g. Individuals who have no reported medical, behavioral health or LTSS needs but may have needs in the future. These individuals are currently not seeking necessary preventative care, testing, or treatment for an existing condition.

Environment greatly influences health and wellness outcomes. Optima Health recognizes regional differences in provider availability and service capacity, but also recognizes that many in this population were served in the Medicaid FFS environment for some time. Optima Health has devoted much effort to creating effective relationships with traditional providers in each region, supporting their services with our care coordination model, thereby assuring that the Care Coordinators and the Interdisciplinary Care Team (ICT) have the resources necessary to provide effective care and service for each individual to meet their needs.

- The identification and description of the established partnerships with community organizations that assist in identifying resources for the most vulnerable beneficiaries, including the process that is used to support continuity of community partnerships and facilitate access to community services by the most vulnerable beneficiaries and/or their caregiver(s).

The Optima Health Model of Care Goals for Chronic / Special Needs Population

Optima Health improves the health and quality of life through its integrated care model. The Optima Health integrated chronic care model is built on identification, stratification, and collaborative engagement among all members of the Interdisciplinary Care Team (ICT), innovative programming, and measurable outcomes to improve quality and to manage cost. The model supports the individual in developing an understanding of his/her chronic condition(s), and ordered medications. To optimize quality of life, it also encourages active decision-making and lifestyle, and access to services in a variety of modalities and resources. The model focuses on person-centered care and the recognition that the individual enrollee is at the center of all care decisions. In ensuring that care is at the right time and in the right setting, Optima Health seeks to reduce unnecessary utilization, support members to safely remain in community settings, and to control the total cost of care.

This model includes enhanced linkage to local contact agencies, in order to maintain members in the community or to facilitate transitions to various levels of care and

residence. Community resources linked to Optima Health to provide support to individuals and their families/caregivers, include, but are not limited to: Centers for Independent Living, Community Services Boards, local area Agencies on Aging, and local faith-based organizations. For members residing in Nursing Facilities (NFs), this also includes utilization of MDS data and collaboration with Ombudsmen to identify and evaluate members who potentially can be supported to safely return to the community.

2. Care Coordination

Element A. SNP Staff Structure - Overview

Optima Health has defined and developed a Model of Care to coordinate the delivery of care for D-SNP beneficiaries based on data driven outcomes and benchmarks. We measure the effectiveness of the Care Coordination program to ensure beneficiaries' healthcare needs, preferences for health services, and information sharing across healthcare staff and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services, and effective software to support tracking and predictive modeling, that ultimately leads to the identification of opportunities for improved healthcare outcomes. The Care Coordination focus includes services furnished in and outside the Optima Health provider network, and/or through a member's Medicaid plan, as well as, responsibilities provided by the beneficiaries' caregiver(s). Our comprehensive Model of Care includes:

- **Defined Staff Structure**: Optima Health offers a full suite of products including Medicare Advantage, Medicaid managed care, consumer-driven, employer-sponsored plans, individual and family health plans, and employee assistance plans. Optima Health employs staff in Administrative, Operations and Clinical areas, which includes collaboration internally and externally, to meet the complex needs of vulnerable SNP beneficiaries and support the Model of Care. Staff report up through key leadership roles, and ultimately to the Optima Health Board of Directors.

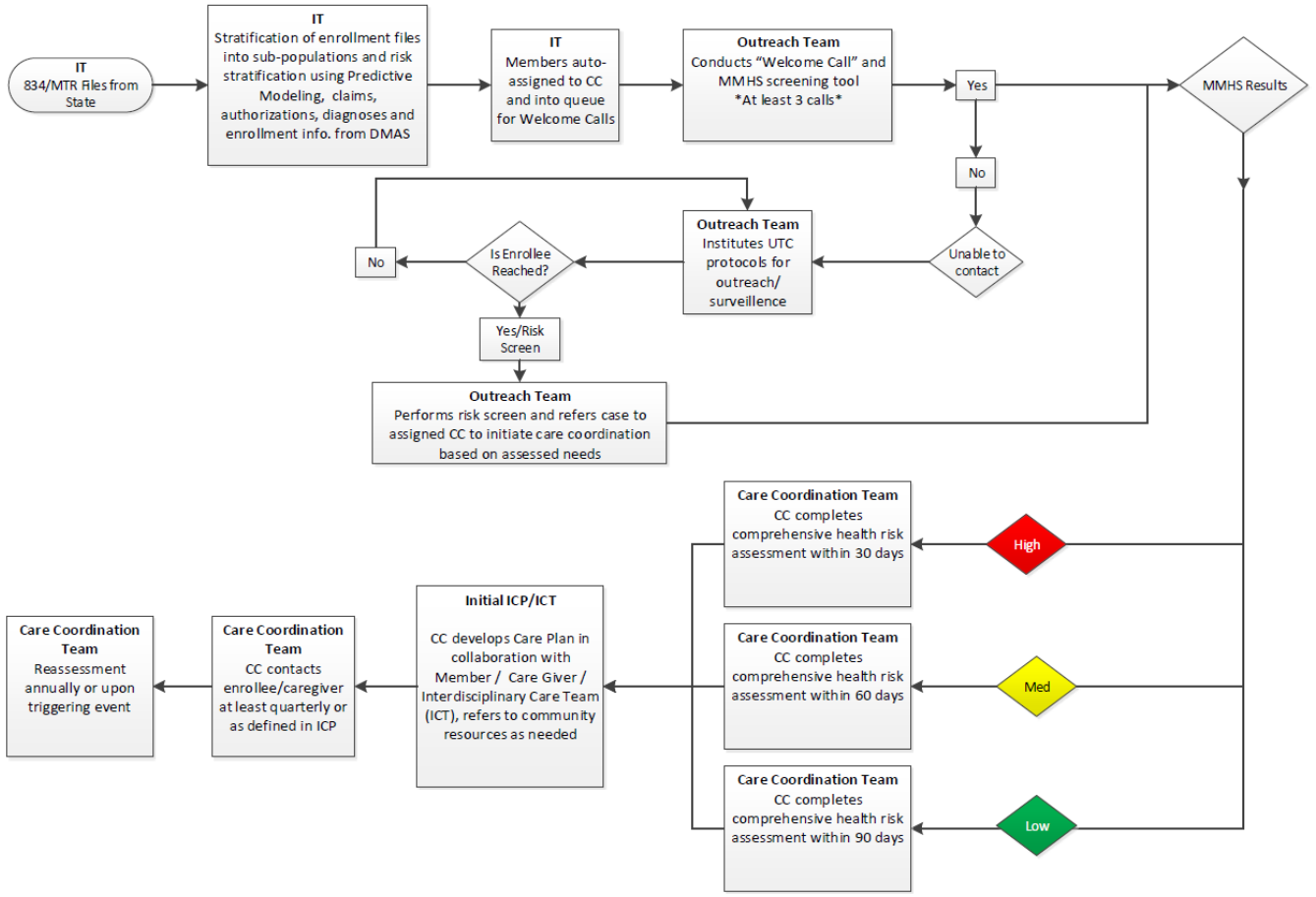
- **Comprehensive Health Risk Assessment**: All enrolled members are assessed using a variety of assessment instruments administered by the Care Coordination specialist. The comprehensive assessment focuses on identifying the member's physical, medical, psychosocial, cognitive, functional, mental health, environmental needs and social determinants of health – all of which are key components. Each beneficiary is reassessed annually, or more frequently, if needed.

- **Individualized Care Plan**: Following the initial assessment process, the member's Interdisciplinary Care Team (ICT) assists in the development and implementation of a comprehensive plan of care and services, in consultation with the beneficiary and members of their family or community support structure. The Care Coordinator coordinates all physical, behavioral health, social, pharmacy and other health related services. The Care Plan is developed with the beneficiary, identifying prioritized goals and objectives including measureable outcomes as well as specific services and benefits to be provided.

- **Interdisciplinary Care Team (ICT)**: The team is comprised of professionals with the relevant experience and qualifications, to have an impact on the member's health, include personal goals and desires, and support the well-being of members, all taking into consideration his/her medical or behavioral health history and assessed needs. The ICT process is most effective when it includes not only the member but also the caregiver(s) circle of support and/or direct-support workers responsible for the day-to-day care in addition to the member's Primary Care Physician (PCP). The core participants of the ICT includes the member/member representative, PCP and Care Coordinator; the addition of other team members is based upon the member's needs, current services, capabilities, and preferences.

- **Care Transition Protocols**: Transitioning from one setting of care to another, or movement from one health plan to another increases the risk of errors, poor communication, and poor coordination between providers, and may directly contribute to rising incidence of preventable adverse events. To address this, Optima Health has developed dedicated regional Transition Care Coordinators (TCC) who work with the member's assigned Care Coordinator and use a Care Transition Protocol. This protocol supports comprehensive transition planning, promotes safety, reduces the risk of preventable hospitalizations or readmissions and ensures the availability of needed supports and services in the community. Thee TCCs coordinate all services (not only those considered a covered benefit) thereby reducing the potential of fragmentation of care with the goal of ensuring optimal outcomes during a high-risk period.

The following chart depicts the overall structure of the model:



MODEL OF CARE COMPONENT	DEFINITION	PERIODICITY/TIMING
1. Risk Stratification of Enrollment	Identification of high-cost/high-need/high-risk groups of members through: • Quantitative Methods – Claims-based Algorithms • Qualitative Methods – Risk Screenings; HRA; Physician Referral, Feeds from Collective Medical with actual ED/Hospital Utilization events, Prealize Predictive Analytics software to identify members with rising medical risk	• Receipt of initial PMMR enrollment file • Following screening/ assessment • Regular intervals
2. Initial Risk Screening & Welcome Call	All new members are contacted within 90 days of enrollment to welcome the member to Optima Health, verify contact information, and conduct an initial health risk screening to identify member characteristics, current services, and immediate needs.	• Initial implementation • Ongoing new enrollment

MODEL OF CARE COMPONENT	DEFINITION	PERIODICITY/TIMING
3. Engagement - Unable to Contact	For difficult to reach and hard to engage members, a method of finding, engaging and connecting individuals with needed care, care coordination, and related social services is used. Multiple attempts in various methods: phone, mail, providers, home visit, claims review, etc.	• Ongoing
4. Assignment of Care Coordinator	Based upon the member category, location of the member, and caseload capacity of each Care Coordinator, each member is assigned to a Care Coordinator.	• Initial implementation • Ongoing new enrollment
5. Health Risk Assessment • Qualification of personnel who conduct the HRA must meet the qualifications of Care Coordinators (RN, LPN or four year degree in Health or Human Services and 1 year experience	The HRA tool provides the care team with insights on the member's care condition and needs. The assessment includes physical and behavioral health of a member, especially conditions that are often comorbid. The process assesses social (including housing and employment), functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains. The member's PCP and specialists, strengths and goals, current service and community supports are identified for incorporation in the care plan.	• Initial assessments in accordance with CMS requirements • Ongoing new enrollment • Reassess-ments at least annually • Upon triggering event or significant change in health or functional status
6. Interdisciplinary Care Team	The ICT brings together the member, member's PCP and Care Coordinator in addition to other participants as appropriate, to address specific member needs. The ICT collaborates to address member issues in a holistic, person-centered approach. The Care Coordinator functions as the leader of the ICT. Special requirements of the member impact the members of the ICT. Examples: 1. The ICT for a member that is homeless or has safety concerns, may include a Housing Specialist. 2. The ICT for a member that is diabetic and morbidly obese may include a Dietitian.	• Timing of initial implementation activities varies by member risk stratification • Ongoing new enrollment by member risk stratification • Upon triggering event or significant change in health or functional status

MODEL OF CARE COMPONENT	DEFINITION	PERIODICITY/TIMING
7. Care Coordination Activities	Care coordination involves deliberately organizing member care activities and sharing information among the ICT to achieve safer and more effective patient-centered care. This requires effective communication between providers, members, and caregivers, using an interoperable infrastructure to enable the transfer of clinical information between care providers. Specific activities include the following mandated services (within required timeframes): • Conducting health risk assessments • Leading ICT review of proposed care needs • Developing an Individual Care Plan (ICP) • Planning and initiation of services identified by ICP • Monitoring of services and member's condition • Reassessment and ICP review	• Timing of initial implementation activities varies by member risk stratification • Ongoing new enrollment by member risk stratification • Upon triggering event or significant change in health or functional status
8. Individual Care Plan (ICP)	An ICP is developed based on member-specific data gathered during the initial risk screening, the HRA, historical claims information, identified care needs, and incorporation of member's needs and preferences. The ICP identifies the services, service delivery provider(s), frequency and amount of services to be provided to meet the member's needs.	• Timing of initial implementation activities varies by member risk stratification • Ongoing new enrollment by member risk stratification • Upon triggering event or significant change in health or functional status
9. Disease Management	Provide disease management programs that improve the quality of life for members with chronic conditions and reduce service utilization and costs (such as avoidable ER visits and hospitalizations) associated with unmanaged disease complications.	Ongoing
12. Care Transitions Program	To support a member's movement from one setting of care to another or into/out of the health plan, the Care Transitions Program promotes the efficient transition of care through intensive, short-term support of members. Program includes discharge planning, outreach, education, member monitoring, and care coordination.	Upon member movement from one setting to another

MODEL OF CARE COMPONENT	DEFINITION	PERIODICITY/TIMING
13. Quality Measurement & Evaluation Framework	Common metrics and monitoring processes for those metrics, both quantitative and qualitative, are critical for meaningful and effective evaluation of the care coordination program. Beyond traditional HEDIS clinical quality measures, specific metrics may include the following domains: • Adherence to ICP and care standards • Critical incidents • Member satisfaction • Member's quality of life • Intermediate health outcomes • Long-term health outcomes	• Ongoing • NCQA requirements
14. Health Information Technology	Symphony by PCS, technology to enable the documentation, tracking, monitoring and communication of care coordination activities and functionality, supporting team-based, person-centered care.	Ongoing
15. UM Functions	Mechanisms to detect both under- and over-utilization of medical, behavioral and LTSS. This includes processes to collect, validate, analyze, monitor and report utilization data. Specific functions include but are not limited to: • Prior Authorization • Concurrent Review • Retrospective Review • Hospital Review • Discharge Planning • Inter-Rater Reliability • Clinical Practice Guidelines • Drug Utilization Review	Ongoing
16. Care Coordination Training	Provide training and oversight to Care Coordinators so their interactions with individuals are evidence based and supported by professional standards. Orientation and ongoing training of D-SNP program, all applicable federal and state requirements, NCQA requirements, structural requirements (i.e., confidentiality, program operations, etc.) are required.	• Initial Orientation • Ongoing

1. Describe the administrative staff's roles and responsibilities, including oversight functions.

Optima Health has assembled a team that is comprised of leaders and staff that leverages years of industry experience to ensure the success of the D-SNP program. Leading the D-SNP Team is Patricia Darnley, SVP of Government Programs, who has extensive Managed Care leadership experience with Medicare, D-SNP and Medicaid Long Term Services & Supports programs.

In addition, Daniel Hoffman, as the D-SNP Project Director, brings over 20 years of managed care experience to lead the Optima Health team to provide the D-SNP program. This team of professionals has experience in developing and managing Medicaid and Medicare Advantage contracts, and draws on support from our corporate PACE and Life Care (nursing facility) programs. Our team demonstrates our commitment to provide an integrated solution for the D-SNP population and "improve health every day" for those that we serve. As the D-SNP Project Director, Dan Hoffman has the ability to make rapid-cycle decisions, including having full authority to make contractual, operational and financial decisions on behalf of Optima Health.

In addition, there are other key roles such as Geoffrey Nichols who serves as Clinical Contract Administrator and whose is experienced in managed care operations, bringing over 10 years of experience and has the role of ensuring contractual requirements are implemented.

Compliance Manager, Selena Tudor completes audits of the program for contract and Model of Care compliance.

The Optima Health Operations Department is dedicated to Enrollment, Eligibility Verification, Claims Processing, Member Services and Administrative Oversight. This team reports to Khaled Ghady SVP, Operations who reports up to Dennis Matheis, President of Optima Health.

The Operations Department supports the following roles and responsibilities:

Enrollment & Eligibility

- Eligibility File Received from Virginia Medicaid (ANSI 834 format)
- Eligibility File Received from CMS
- Error Reports
  - Membership Error Reports (name, DOB, gender discrepancies)
- Enrollment Accuracy > 99%
- Member ID Card and Member Material Production and Distribution
- Updates to the DMAS portal for changes in Medicaid Member statuses, to include: hospice, intermediate care facility, skilled nursing facility, elderly and consumer directed waiver, technology assisted waiver, or long stay hospital.

Claims Administration

- Claims per Month Received
  - ~ 450,000 for total book of business
  - ~ 200,000 for Medicaid
- Claims Auto-Adjudication Rate
  - 83% for total book of business
- Non Auto-Adjudicated Claims Rate = 17%

- Manual claims processed internally
- Aggressively managed
- Paid within 20 days = 96%
- Paid within 30 days = 98%

- Financial Accuracy > 99%
- Weekly Claims Audit
- Annual Audit of Internal Controls (Model Audit Rule)

System Administration

- Benefit Configuration and Set up
  - Responsible for system configuration to load benefits
  - Ensure accurate adjudication of benefits/claims
- Provider / Facility Data Load
  - Physicians, facilities, and, ancillary providers
    - Demographic
    - Reimbursement terms
    - Fee schedule loads
- Daily and Weekly Auditing
  - Business and Systems Integration
- Responsible for development of business requirements to configure the system to meet contractual obligations
- System testing, including but not limited to user acceptance testing (UAT) and regression testing
- Auditing of operations functional areas
  - Claims
  - Customer Service
  - Enrollment
  - Benefit Configuration
  - Provider/facility set up and maintenance
- Training (new and ongoing) to include computer-based training (CBT)
- Operations management and ad hoc reports, like red light, green light (RLGL)

Customer Services (Call Center Services)

- Consists of member and provider services
- Committed to providing quality and personalized service
- Respond to inquiries related to claims, benefits, and eligibility

Call Center Technology

Panviva:

- Tool used by Customer Service Representatives to retrieve relevant information, like eligibility, benefit, and provider data while speaking with members
- Increases accuracy and speed to resolution

Witness:

- State of the art recording system
- 100% of calls recorded
- Conduct post call surveys for customer satisfaction feedback

- Telephonic post call survey consists of five questions regarding effectiveness and overall customer satisfaction
- Member and provider satisfaction is >90%

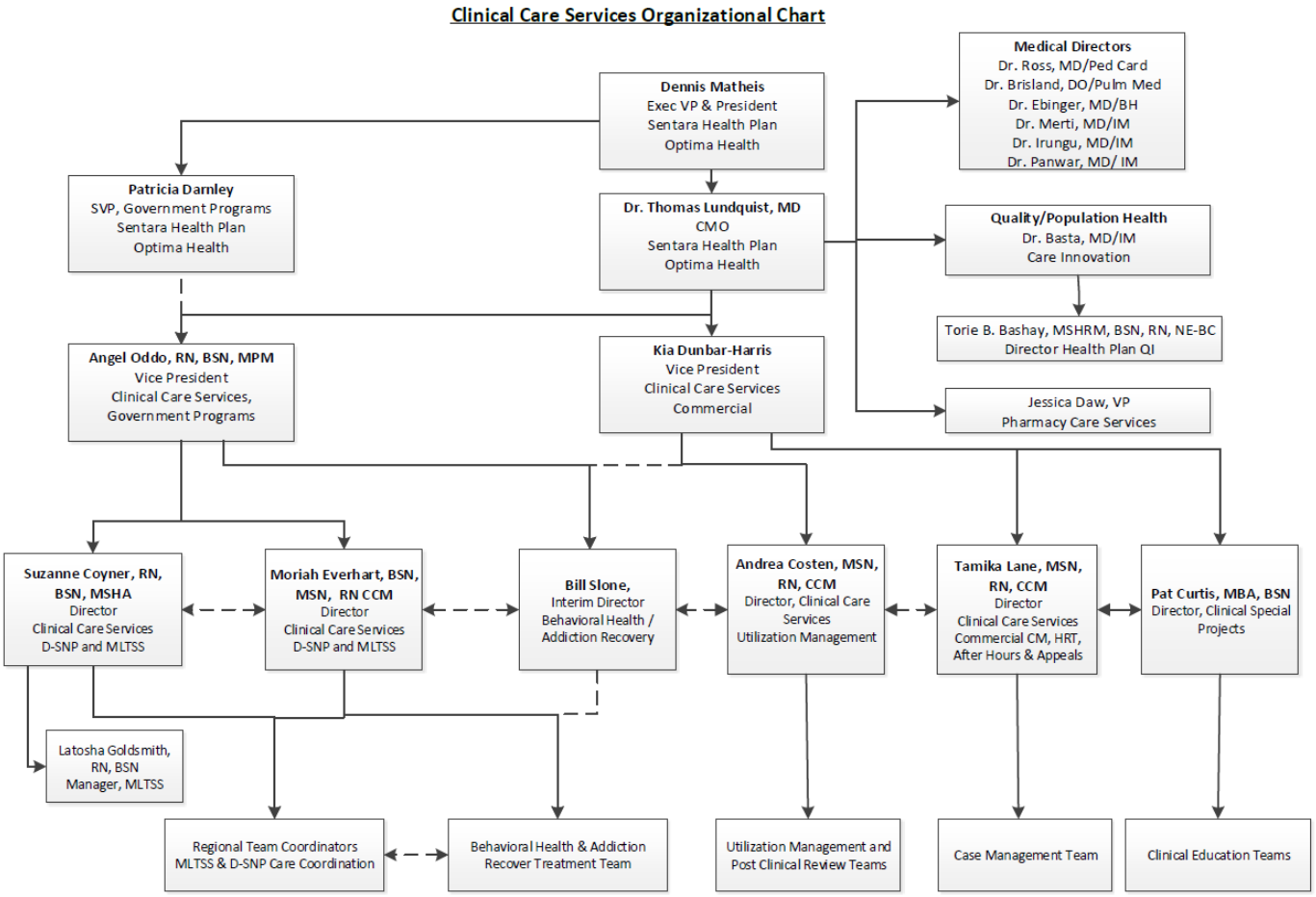
- Real time service recovery to perform immediate outreach post survey

Quality Management Program

- Quality monitoring of customer calls and transactions is conducted to ensure accuracy of information and service delivery
- Call monitoring system captures both audio and video (screen capture / scraping) ~ 30%
- Approximately 500 calls per month (1%) of the recorded calls are monitored and graded for "Call Quality," trends, and educational opportunities

2. Describe the clinical staff's roles and responsibilities, including oversight functions.
3. Describe how staff responsibilities coordinate with the job title.

The Optima Health organizational structure for the clinical team includes individuals responsible for credentialing, management, medical oversight, behavioral health oversight, long-term services and supports oversight, pharmacy oversight, quality, and utilization management. This team is led by our Chief Medical Officer, Dr. Thomas Lundquist, who reports up to Dennis Matheis, President of Optima Health.



The foundation of the clinical care program is the D-SNP Care Coordination team. Care Coordinators are the member's primary source of accountability and contact. They support the member through education, assessments, Individualized Care Plan (ICP) development, and the Interdisciplinary Care Team (ICT) processes. The Care Coordinator directs beneficiary care and education on self-management techniques. Each Care Coordinator reports to a Team Coordinator and then a Regional Manager, and ultimately to a Clinical Director. The Clinical Director reports to the Vice President of Clinical Care Services who reports to the Chief Medical Officer (CMO).

D-SNP Care Coordinators report up to the same leadership as the LTSS Care Coordinators. Whenever Optima Health is the health plan for both the D-SNP and the LTSS services, a single Care Coordinator is assigned and manages the care and treatment coordination of the beneficiary. Please see organizational chart above for reference.

Optima Health may use contracted Care Coordination services with existing vendors for telephonic care coordination with members. These Care Coordination services are designed to replicate the training, services, and interventions available to all D-SNP members whether or not they are managed by an Optima Health employed Care Coordinator or a contracted Care Coordinator vendor. If utilized, Care Coordination services will be fully delegated with full clinical and contract

oversight.

Transition Care Coordinators are charged with assuring that members who are moving from one care/residential setting to another are educated, supported, and monitored to assure successful transitions. In the following sections specific to transitions, their role is more fully described.

The ICT is comprised of both Optima Health staff and contracted providers. Their function is to review the ICP, evaluate its initial and ongoing appropriateness, and contribute expertise to the plan. Optima Health contracts with Pharmacy, Behavioral Health and Medical personnel and actively seeks their participation in the ICT and management of the beneficiary.

Changes to the member's assigned Care Coordinator or when the Care Coordinator is temporarily absent are communicated to the member, with instructions on how to reach the Care Coordinator filling in or newly assigned. Care Coordinators use out-of-office voicemail and email messages to direct callers to the appropriate person assuming the responsibilities. Supervisory Staff are accountable for all members assigned to Care Coordinators under their purview, and can intervene when needed. In addition, a main Care Coordination support line is supported Monday through Friday from 8:00 A.M. EST – 5:00 PM EST to assist members with contacting their assigned care coordinator or to address issues that may be handled by Care Coordination technicians. For example, Care Coordinator Technicians provide telephone support for field deployed care coordinators, schedule appointments with members and providers on behalf of the member and the ICT process, assist members with transportation or in-network provider assistance, and handle and track a variety of clerical and administrative tasks associated with care coordination services.

Staff oversight includes:

- license and competency verification that relates to the specific population being served by Optima Health;
- data analyses for utilization of appropriate and timely health care services;
- utilization review;
- case management/care coordination;
- transition of care;
- qualitative and quantitative chart audits performed by Team Coordinators; and,
- provider oversight to ensure use of appropriate clinical practice guidelines and integration of care transition protocols.

4. Describe contingency plans used to address ongoing continuity of critical staff functions.

Optima Health has a detailed and extensive Business Continuity Plan (BCP), designed to minimize the risk to Optima Health members. In the event of a serious disruption, key processes or functions are established in the Business Continuity Plan, noting the timeframe these key processes and functions need to be back online.

The Business Continuity Plan defines the various resources needed for different levels

of disruption and these resources include: Building, Materials and Equipment; Personnel; and Time.

The purpose of the Business Continuity Plan is to:

- Protect the health and well-being of the Optima Health employees located in the Virginia Beach and Richmond office buildings, as well as any other regional locations.
- Safeguard the vital records and resources of Optima Health business operations
- Provide a structure that will define the steps required to restore normal business operations as quickly as possible.
- Ensure the appropriate resources and personnel exist to expedite the restoration of business operations.
- Guarantee critical services and processes are available to Optima Health statewide members and providers.

In accordance with Optima Health's Emergency Incident Command System (ICS), the Senior Leadership Team (President, COO, CFO) has the authority and responsibility to initiate disaster recovery/business continuity plan activities, to direct utilization of resources during the disaster event and to terminate the disaster response. The ICS is an emergency management system which employs a logical management structure, defined responsibilities, clear reporting channels, and a common nomenclature to unify the health plan with the rest of Sentara Healthcare, and other emergency responders.

OHP's ICS organizational structure is made up of a chain of command which incorporates four sections under the overall leadership of the Incident Commander:

- Finance Section Chief
- Planning Section Chief
- Logistics Section Chief
- Operations Section Chief

The Section Chiefs each have reporting accountability to the Incident Commander for all functional areas assigned within his/her span of control. Each Section Chief will ensure open lines of communication with the Incident Commander through the use of Job Action Sheets, which are detailed position descriptions prioritizing a list of emergency response tasks. Activation and termination of department-specific Standard Operating Procedures (SOPs) will be communicated via this process. In order to rapidly communicate with all employees, alerts are sent through an automated system by email, text, and phone communications. Depending upon the nature of the situation, immediate actions may include removing early refill limits on prescriptions, relaxing authorization requirements for care, and other necessary steps to serve our members

without interruption.

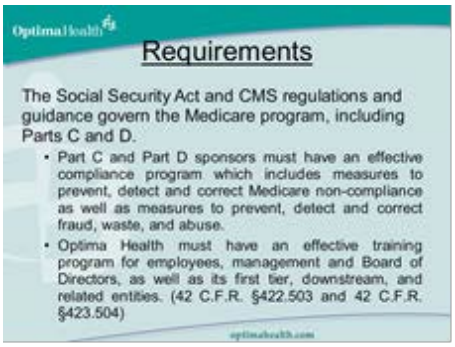
5. Describe how the organization conducts initial and annual MOC training for its employed and contracted staff.

All Optima Health staff, employed or contracted, working with D-SNP members receive mandatory training on the specific Model of Care (MOC) elements and Medicare Compliance at the time of employment and annually thereafter. Specific employees who are required to complete the training are those who have either direct contact with the members, providers or may be part of the Interdisciplinary Care Team (ICT). Model of Care training also includes providers: initial training and annual refresher training is provided to facilitate knowledge and understanding of program requirements, enhance interdepartmental collaboration, and emphasize care coordination.

Our team ensures the quality of care for D-SNP members by applying current training processes used by Optima Health. Operational and compliance training programs are delivered by formal instructor-led and preceptor training programs; via OneLink, our online web-based Optima Health learning management system; and informal team learning opportunities. The OneLink system assigns mandatory courses to staff, such as annual MOC review and Compliance coursework, and tracks completion. OneLink also provides on-demand learning opportunities.

Optima Health has developed and delivered a D-SNP overview course to be required of all current staff, and as part of orientation, to new staff within the first two weeks of hire. This training is delivered either face-to-face, WebEx, or computer-based, describing federal and state requirements pertinent to D-SNP populations and sub-populations. Staff is also required to complete an annual refresher course. Additional training is developed and delivered on an ad-hoc basis to ensure all Care Coordinators and other Optima Health team members who serve D-SNP members have a comprehensive understanding of the requirements and goals.

All staff that work with D-SNP beneficiaries receive new hire and annual mandatory Medicare Compliance Training. See training section below. Annual Medicare Training includes the following:



Training methods, content, and timing are continually adapted to reflect revised policies, outcomes of Optima Health Quality Improvement activities, results of member satisfaction surveys, and evaluation of staff performance. As a result of Quality Improvement activities, "just-in-time learning" is created by the Care Coordination training department and disseminated to staff using the "Tip of the Week" format, followed by posting to the SharePoint site for all staff to reference. Printed documentation from training sessions is also posted on the SharePoint site. Additionally, real-time training occurs during quarterly staff meetings, weekly team huddles, monthly staff performance feedback sessions, and written annual reviews.

6. *Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.*

All face-to-face training attendance and completion is recorded by managers, via attendance sign-in sheets. For OneLink, attendance of any training requires registration and is electronically recorded after the class/training, and transcript summaries are provided. The system tracks completion and sends reminders to both staff and their managers when required training has not been completed. Annual MOC training and Medicare Compliance training is provided and automatically tracked in OneLink. Reports are automatically generated and distributed before deadlines, to ensure completion by all staff. Managers can also look up completion of training on an ad-hoc basis. OneLink training records automatically populate annual staff performance appraisals with complete transcripts.

Example of employee education transcript tracked in our online education module OneLink:

Title	Required	Status	Due Date	Start Date	Completion Date
Utilization Management Process...		Completed		10/06/2016	10/06/2016
Compliance and Privacy	✱	Completed	11/30/2016	08/30/2016	08/30/2016
Preventing Workplace Violence	✱	Completed	11/30/2016	08/30/2016	08/30/2016
Medicare Parts C & D Complianc...		Completed		08/30/2016	08/30/2016
Special Communication Services	✱	Completed	11/30/2016	08/29/2016	08/29/2016
Employee Acknowledgement Forms	✱	Completed	11/30/2016	08/29/2016	08/29/2016
OneLink Job Profile Acknowledg...	✱	Completed	11/30/2016	08/29/2016	08/29/2016
Business Continuity Plan		Completed		08/29/2016	08/29/2016
Special Communication Services	✱	Completed	12/15/2015	12/15/2015	12/15/2015
Utilization Management Process...		Completed		10/05/2015	10/05/2015

7. Describe the actions the organization takes if staff do not complete the required MOC training.

Managers and supervisors of the Care Coordination department, along with the assistance of the training manager, are responsible for conducting the required training. Annual performance appraisals include OneLink training transcripts. All staff are evaluated on the timely completion of all mandatory training. For staff, incomplete mandatory training such as the required Compliance training program results in performance counseling, up to and including: termination per the Sentara and Optima Health policies.

To assure compliance of training by contracted entities, any contracted vendor will be required as part of the contract, to provide proof of annual training for each employee and as requested.

Element B. Health Risk Assessment Tool (HRAT) - Overview

In accordance with 42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv), Optima Health Care Coordinators use a comprehensive Health Risk Assessment (HRA) tool to conduct an in-depth clinical assessment, which gathers information about the member's health status and needs across physical, psychosocial, behavioral, social, functional, cognitive, Long Term Services and Supports (LTSS), wellness and preventive domains. Member-specific information obtained through the HRA tool provides a snapshot of the member's needs, which assists in determining the appropriate level of intervention. The HRA consists of a series of questions that use branching logic to expand the questions based on the answer. For example, if a member states she/he is a diabetic, another set of assessment questions about diabetes are presented to delve deeper into the member's disease state. Self-reported outcome measures are also collected during the assessment process and documented in the HRA tool. Examples of the outcome measures include the member's perception of their health, depression scale, and functional status. The HRA tool is used to not only identify any immediate needs a member may have when joining Optima Health or any changes since the last assessment, but also a tool to identify the need(s) for a referral to other programs and community benefits.

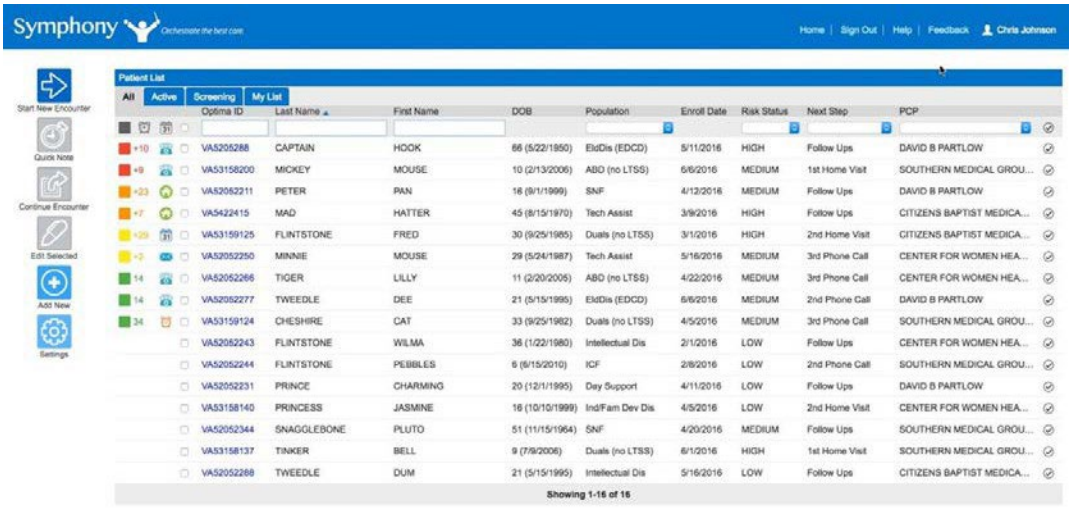
1. How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary (Element 2C).

The HRA tool and the results are documented electronically in our care management system, Symphony™ by PCS, which includes branching logic to probe into multiple clinical areas for risk factors and includes specialized assessments for specific conditions. Symphony is a cloud-based care coordination and workflow management system and is accessible on laptops, iPads, or tablets, allowing for real-time documentation. The HRA captures information on the member's Primary Care Provider (PCP) and specialists, member-specific strengths, barriers, and goals, identifies the use of community resources and identifies all service providers including Targeted Case Management (TCM) services from a Community Services Board (CSB). This information enables the Care Coordinator to reach out to the appropriate service providers, share results and avoid duplication of care coordination services.

The results of the HRA also identifies a list of opportunities, which may include gaps in care, educational needs, and service needs. These results and the risk score automatically pre-populate information into an Individualized Care Plan (ICP) with potential interventions and actions to improve the member's health status.

The HRA tool includes Medication Reconciliation functionality. Pharmacy claims files are imported into the Symphony™ Care Management system daily. The Care Coordinator can view the pharmacy claims and populate a medication list from the claims list. This functionality reduces manual entry and error in the creation of the medication list. Ease of access and review increase the ability of the Care Coordinator to complete Medication Reconciliations during any care setting transition.

The tasking feature within Symphony™ allows Optima Health to assign and track the completion process of each HRA. For each member enrolled in our program, an HRA task and due date are assigned based on the timeframes and designation type outlined in the Model of Care Assessment and Individualized Care Plan Expectations table. The Care Coordinator assigned to the member ensures the HRA is completed within the required 90 days from the date of enrollment or captures attempts to contact the member to schedule the HRA. Symphony creates alerts and reminders to signal the need for the Care Coordinator to take action. Reports are created indicating date of enrollment, the date of the initial health assessment, and the personnel who conducted the assessment. The Care Coordinator Supervisor has access to a dashboard within Symphony that displays assessment dates and identifies assessments in danger of being completed outside of the established requirements. By having these processes in place, Optima Health ensures the timely completion of HRAs. The screenshot below depicts the dashboard, which can be used by the Care Coordinator Supervisors for tracking and monitoring of HRA completions.



2. How the organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information (Element 2D).

The HRA results are reflected in the Individualized Care Plan. The member and data identified Strengths, Challenges, Barriers, Social Determinants and Gaps in Care are imported to the ICP. The identified problems suggest an ICP outline to the Care Coordinator with proposed Interventions and Actions. The Care Coordinator uses this information to develop the ICP, in conjunction with the member, and according to the members' wishes. The ICP is then reviewed and finalized with the ICT, which includes the member. Sharing results from the HRA and risk stratification at the ICT meeting,

3. How the organization conducts the initial HRAT and annual reassessment for each beneficiary.

HRAs are conducted by the Care Coordinators, who are licensed Registered Nurses, Licensed Professional Nurses, or individuals with a four-year Health and Human Services degree. The staff conducting such assessments have experience with persons with complex medical needs and receive additional focused training to support members with limited English proficiency, health literacy, intellectual capability, and other challenges that this population faces. Motivational interviewing and engagement techniques are also practiced in training.

An Initial HRA is completed within 90 days of enrollment. Eligibility files, with any available authorization and encounter data, are loaded into Symphony Care management system. Members are stratified based upon available data, and assigned to Care Coordination teams according to eligibility, location, and initial risk stratification. before conducting the HRA, the Care Coordinator compiles available data, including: the member demographics, claims, pharmacy data, provider's EMR, and information by and about available family/caregivers. The HRA is conducted telephonically for low-risk members, for members living in remote areas and for members refusing a face-to-face visit. The HRA is completed in a culturally and developmentally appropriate manner and shall consider a member's physical and cognitive abilities and level of literacy in the assessment process.

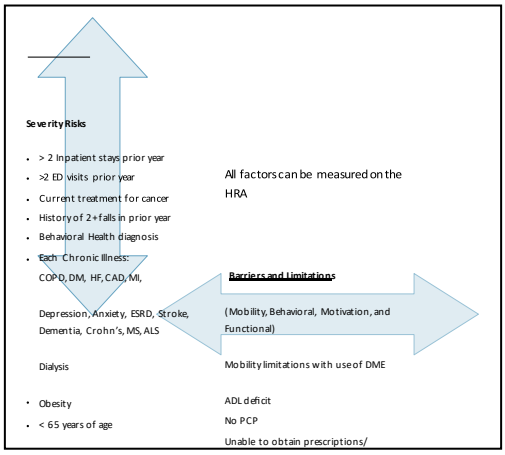
At the HRA encounter, the Care Coordinator explains the purpose/program/benefits and conducts the assessment using open-ended conversational questions, verbal and non-verbal cues, and records the responses in Symphony care management system. Symphony questions follow the typical interview process, the interviewer may change the order of the questions and complete in any order, depending on the response of the member. Branching logic, which prompts additional probative questions are imbedded in the HRA logic. If the member is unable to complete the assessment in one session, the Care Coordinator saves the document, creates a follow-up reminder at an agreed-upon time and submits the documentation.

Symphony automatically schedules and sends reminders when the next intervention or Assessment is due. The reassessment can also be completed prior to the 365-day deadline when a triggering event occurs, or as deemed appropriate by the member's Care Coordinator, and upon member request. These triggering episodes can include, but are not limited to:

- Member hospitalization,
- Significant change in health, functional, and/or residential status,
- Change in the services the member utilizes, or
- Request for a new service.

4. The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results.

Members are stratified into subpopulations such as Nursing Facility, Waiver with or without Private Duty Nursing (formally known as the Commonwealth Coordinated Care Plus Home and Community Based Waiver) Emerging Vulnerable, and Other Vulnerable based on available eligibility files, claims, and diagnoses codes. The Care Coordinator utilizes the results of the HRA to confirm the appropriate stratification level for the Member and to form the basis for developing the ICP. These subpopulations also help to determine if a member should be managed face to face or telephonically and help to determine the frequency of contact by the Care Coordinator with the member.



Engaging and soliciting input from members and/or their authorized representatives can be challenging for them, and they may not be prepared to participate in ICT's. The strategies that Optima Health uses help to engage and solicit input from the various ICT participants include:

- Promoting transparency of information in an understandable fashion,
- Sharing results from the HRA and risk stratification at the ICT meeting, and
- Utilizing Risk Stratification to guide the Care Plan needs.

To improve the care coordination process, risk stratification results provide objective data to determine ICP, as well as the scope and frequency of actions and interventions. The assessment further identifies opportunities, gaps, strengths, and barriers, which lead to the development of the ICP. Symphony incorporates the assessment data in the ICP ensuring that each element of the HRA, including a description of services to be provided until the next person-

centered ICP review, is reflected in the risk stratification, and ultimately the ICP, ensuring that all relevant aspects of the member's care are addressed in a fully integrated manner on an ongoing basis.

> *Example: A member identified by the Care Coordinator as Uncontrolled High Risk, is in need of increased Provider visits, closure of gaps in care, resources to reduce barriers to care and connections to community partners to supplement services. The ICP developed addresses the identified needs and the increased frequency of these interventions: Specialist appointment, frequent primary care appointments, missed required health screenings, and transportation/financial constraints. The high-risk uncontrolled category also indicates the need for additional Care Coordinator face-to-face visits each quarter, as opposed to a low-risk controlled member would typically be followed telephonically.*

Symphony also identifies the most at-risk sub-populations, which are categorized as 'Other Vulnerable':

- **Frail –** may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF that increase frailty
- **Disabled-** members who are unable to perform key functional activities independently such as ambulation, eating or toileting; for example, members who have suffered an amputation and blindness due to advanced diabetes
- **Dementia –** members at risk due to moderate/severe memory loss or forgetfulness
- **End-of Life-** members with a terminal diagnosis, such as end-stage cancers, heart or lung disease
- **Complex and multiple chronic conditions** – members with multiple chronic diagnoses that require increased assistance with disease self-management and with navigating health care systems
- **Serious Mental Illness** – members with behavioral health diagnoses which impact their ability to perform everyday activities, such as Schizophrenia or Schizoaffective Disorder, Psychotic Disorder, Post-Traumatic Stress Disorder, Bipolar or Mania, etc.

Through Symphony, the Care Coordinator can share information in an easy to read and understandable format. The system grants ICT participant's access to the ICP and other member-specific information, allowing the ICT to remain current on the member's status, challenges, identified problems, and progress towards meeting the member's goals.

Element C. Individualized Care Plan (ICP)

1. The essential components of the ICP.

The Individualized Care Plan (ICP) is based on member-specific data gathered during initial risk screenings, the Health Risk Assessment (HRA), historical claims information, identified member care needs, caregiver input, and incorporates the member's unique needs and preferences. Based on the gathered information, the ICT, which includes the member, develops and implements the person-centered ICP. The ICP components must include, but are not limited to:

- ICP Completion date;
  - ICP attainable goals and objectives with start date; target end dates; completion dates; and outcome measure based assessments;
- Strategies and actions,
  - including interventions and specific services to be implemented to meet the member's needs and personal healthcare preferences,
    - establish preferred language and method for communication
    - Advanced Directives,
    - legal guardianship, and
    - including community-based resources, service provider information, quantity, frequency, and duration of the services or the person(s) responsible for the specific interventions/services (including peer supports);
- Documentation within the ICP regarding progress towards goal completion
  - noting success;
  - the rationale for extending target end goal dates;
  - updating of ICP with new goals;
  - any barriers or obstacles;
- Identification of the member's primary care provider and specialists, including plans for follow-up care;
- Member's informal support network and services;
- Addressing all needs of the member
  - functional, medical, behavioral, cognitive, social, LTSS, wellness and preventive
  - Preferences, as identified by the Individualized Care Team (ICT) and agreed upon by the member.
    - Social needs include but are not limited to: housing, food, security, economic security, community and informational supports, and personal goals (e.g. go to school, have a job, be at granddaughter's wedding);
- Prioritized list of concerns, preferences, needs, goals, and strengths, as identified with the member;
- Advance directive information;
  - Including the education needs of the member about advance directives, and obtaining an advance directive documentation and filing them in the member's file.

  - The status of advance directives must be reviewed at annual assessments and with a significant change in health or functional status and shall be included in the ICP.
  - Also included is documentation of information regarding the inability to provide information regarding advance directives and the reasons why the advanced directives may not have been obtained;
- Plans for Transition coordination and services for members in nursing facilities who wish to move to the community;
- Addressing health, safety (including minimizing risk), and welfare of the member.
- For CCC Plus Waiver members: back up plans, as appropriate in the event that the primary caregiver is unable to provide care.
  - If applicable, the use of skilled respite nursing, trained backup caregivers, and facility admission may be required.
  - All technology-dependent members must have a trained primary caregiver who accepts responsibility for providing care whenever nursing is not in the home and,
  - if applicable, members must have a back-up plan if personal care services cannot be rendered as planned;
- Crisis plans for members with behavioral health needs:
  - describe how to assist the member to identify and select individuals or agencies that will provide support, crisis intervention, crisis stabilization or other services (including peer supports) to assist the member in managing the crisis and to minimize emergency room or inpatient needs;
- Plan to access needed and desired community resources and non-covered services;
- Member's choice of services
  - including a model of service delivery for personal care and respite – consumer- directed vs. agency-directed when appropriate for CCC Plus Waiver members; and,
- Elements included in the Provider Plan of Care (DMAS-97AB) for CCC Plus Waiver Members receiving personal care services and the DMAS-301 for Members receiving ADHC; and,
- Elements included in the Home Health Plan of Care (CMS-485) for Members receiving Private Duty Nursing.
- Elements included in the Nursing Facility Plan of Care (MDS) for Members residing in long term care facilities.

2. The process to develop the ICP, including how often the ICP is modified as beneficiaries' health care needs change.
3. The personnel responsible for the development of the ICP, including how beneficiaries and/or caregivers are involved.

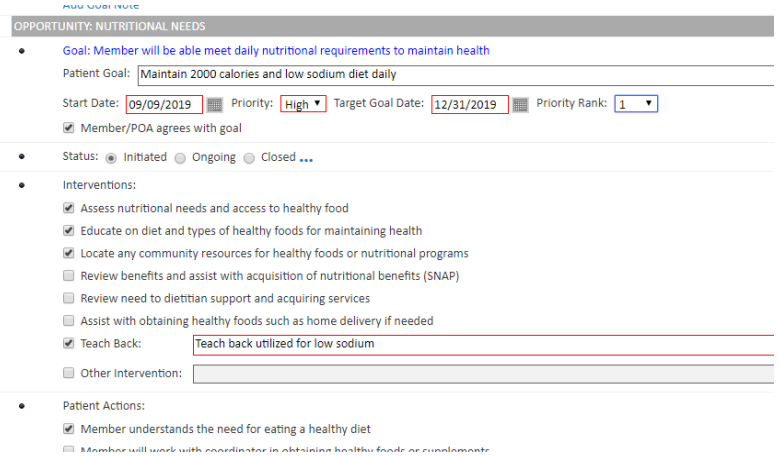
Optima Health Care Coordinators are trained to develop individualized, person-centered, culturally competent ICPs that incorporate the interventions necessary to improve the member's health status across all conditions and reflect each individual's self-management goals, objectives, and preferences. A person-centered approach is

not limited to health status, but also encompasses values of independence, control, and autonomy. It begins by identifying the strengths, preferences, needs, and desired outcomes of the individual. The individual's personally defined outcomes, preferred methods for achieving them, supports and services needed to achieve those outcomes, all become part of the ICP.

As the leader of the ICT, the Optima Health Care Coordinator identifies potential ICT participants based on the information gathered about the member. The ICT may include any or all of the following: the member, any persons the member wishes to include, caregiver, the PCP, the Care Coordinator, medical care providers, LTSS providers, behavioral health specialists, social workers, and others appropriate for the member's medical diagnoses and health condition, co-morbidities, and community support needs. The Care Coordinator initiates an ICT meeting with the member and all appropriate providers/representatives to develop the ICP.

To support our person-centered approach, the Care Coordinator offers the following assistance in developing a person-centered ICP:

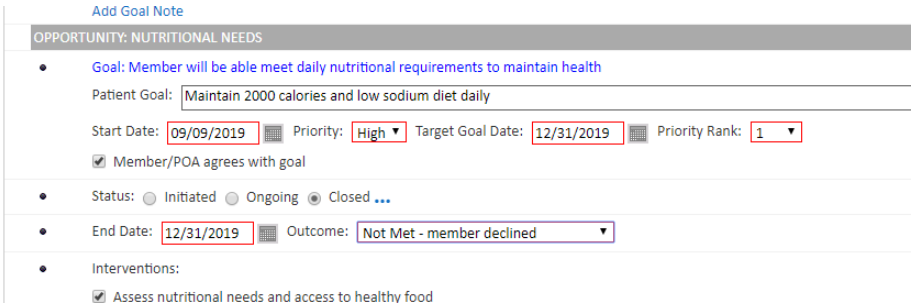
- Support the member to have a meaningful role in planning and directing their own care to the maximum extent possible;
- Provide adequate information and teaching to assist the member in making informed decisions and choices;
- Address all questions and service issues raised by the member;
- Provide a continuum of service options that support the expectations and agreements established through the care planning process;
- Advocate for the member as the need occurs;
- Allow the member to identify their role, and the role of the caregiver, in interacting with the service delivery system;
- Provide the member with flexible and creative service options;
- Educate members about Consumer Directed care options for delivery of designated services;
- Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education, and employment;
- Involve the member and the member's family in strengths and needs identification;
- Assist the member to identify meaningful and measurable goals for him/herself. Goals should be built on the member's strengths and include steps that the member will take to achieve the goal(s);



- Identification of goals met and not met, and
- Ensure all member interactions with the ICT are conducted consistent with the member's cultural preferences and address any language or cognitive barriers.

Each ICP defines the Interventions which are completed by the Care Coordination team and the actions which are completed by the member. This clearly defines the member's participation and role in reaching the Goals.

When goals are not met within the expected timeframe, the Care Coordinator works with the member, their caregiver and may convene the ICT to evaluate the current ICP and determine appropriate alternative actions. Each completed intervention and action is reviewed by the team. Interventions and actions may be reinstated, repeated, or amended. Members of the ICT may also suggest new Interventions or Actions that will assist in meeting the Goal.



A Goal may be closed as "Not Met" for the following reasons: Member Declined, Member Dis-enrolled, or Member Deceased.

Essential elements of the ICP include (described in more detail above, summarized here), but are not limited to:

- Identified needs, and member preferences,
- Self-Management goals and priority of goals to address identified needs,
- Short and long-term goals, including milestones and time frames for re-evaluations,
- Specific interventions to achieve goals,
- Frequency of follow-up/monitoring to achieve goals,
- Capture of the member's consent, input and approval of the ICP,
- Member self-management and collaborative approaches, including family participation,
- Resources to address the appropriate level of care and planning for continuity of care,
- Ongoing assessment of the member's progress toward identified goals,
- Barriers to achieving identified goals, and
- Measurements to prompt modifications of goals, as needed.

In order to address the complex needs of this subpopulation and associated high-risk stratification, all ICPs include specific and unique interventions based on member strengths, goals, needs, and preferences. Because early identification and intervention are especially critical for individuals who are high-risk, our protocols prompt the identification of members for interventions as quickly as possible. Results of the Risk Stratification impacts the ICP in the following ways:

- Identifying needed resources from providers and community partners,
- Determining unmet medical and behavioral health needs,
- Closing Gaps in Care,
- Measuring and predicting adherence and control of Chronic Conditions,
- Addressing over/under utilization (i.e. inappropriate use of the ED as primary care),
- Determining frequency of Care Coordination intervention, and
- Creating action plans for the member and caregiver.

4. Describe how the ICP is documented and updated and where it is maintained.

All ICPs are documented and maintained in Symphony care management system. The Care Coordinator is able to share, in hard copy or on the secure member/provider portal, the Symphony housed ICP and other information in an easy to read and understandable format. The system allows the ICT and authorized providers access to the ICP and other member-specific information, which allows the ICT to remain current on the member's plan, status, challenges, identified problems, and progress towards meeting the member's goals.

The initial ICP is communicated to the member and ICT verbally, during ICT meetings, visits, and phone calls with members. Revisions are made available to all parties, through the portal, and printed/mailed upon request. The member or a designated representative receives a hard copy of the ICP during Care Coordinator visits, and is instructed on how to obtain it through the member portal. Providers are supplied with an initial ICP through the Optima Health secure provider portal, secure encrypted email, by fax, or by mail. Other members of the ICT can receive a copy of the ICP by all the above-mentioned means, excluding the provider portal.

Problems
Knowledge Deficit
Adherence to Treatment Plan
Inappropriate Utilization
Care Plan
OPPORTUNITY: KNOWLEDGE DEFICIT
Improve Health Literacy, health outcomes and self-management Start Date: 01/16/17 Priority: High Patient agrees with goal. Patient Goal: Wants to stay out of the hospital
Status: Initiated
Interventions: Assess current knowledge of condition Obtain Treatment Plan from Provider or Hospital Summary Educate member on condition and Treatment Plan Provide educational materials to reinforce education
Actions: Attend appropriate follow up appointments Verbalize teach back of education Demonstrate ability to self-manage condition
Goal Notes: 1/12/16 educated member on discharge follow up CLC 1/17/17 Reviewed Treatment Plan from PMP and educated member on proper testing schedule CLC
OPPORTUNITY: ADHERENCE TO THE TREATMENT PLAN WHICH CAN BE IMPACTED BY CARE COORDINATION
Status: Ongoing
Interventions: Assess current knowledge of condition Educate on importance of Treatment Plan Educate member on resources
Actions: Obtain medication or equipment Seek and obtain needed resources Demonstrate ability to follow treatment plan
Goal Notes: 1/12/17 needs appt for new order. CLC 1/15/17 Appt scheduled 1/16/17 with PMP, obtain current Treatment Plan and testing schedule CLC 1/17/17 Reviewed Treatment Plan from PMP, started Med Box to help member remember medication on time CLC
OPPORTUNITY: INAPPROPRIATE UTILIZATION OF THE ED, INPATIENT , OR OTHER PROVIDERS
Reduce inappropriate utilization associated with the ED or other Provider Start Date: 01/16/17 Priority: High

The following example illustrates a member with medication non-compliance. In this example, the Care Coordinator conducts thorough and ongoing medication reviews and provide members with printed and/or verbal education on their medications, arranges for pharmacist review of complex medication regimens or regimens for which numerous interactions are identified through drug interaction screening software and indictor flags, coordinate/facilitates communication with the provider as needed, and assists the member to obtain devices to promote adherence (such as pillboxes, pill cutters, and reminders):

OPPORTUNITY: ADHERENCE TO THE TREATMENT PLAN WHICH CAN BE IMPACTED BY CARE COORDINATION
Status: Ongoing
Interventions: Assess current knowledge of condition Educate on importance of Treatment Plan Educate member on resources
Actions: Obtain medication or equipment Seek and obtain needed resources Demonstrate ability to follow treatment plan
Goal Notes: 1/12/17 needs appt for new order. CLC 1/15/17 Appt scheduled 1/16/17 with PMP, obtain current Treatment Plan and testing schedule. CLC 1/17/17 Reviewed Treatment Plan from PMP, started Med Box to help member remember medication on time. Medication Reconciliation Complete by Pharmacist, Education materials reviewed with member. CLC

5. How updates and modifications are communicated to the beneficiary and other stakeholders.

The update and modifications to an ICP are communicated to the member and ICT verbally, during ICT meetings, visits, and phone calls with members. Revisions are made available in writing to all parties, through the mechanisms described above. The member or a designated representative receives a hard copy of the ICP during Care Coordinator visits, and have access to it through the member portal. Providers are supplied with any updates through the Optima Health secure provider portal, secure encrypted email, by fax, or by mail. Both the member and provider portals are updated with any changes to the ICP on which they occur. Other members of the ICT can receive a copy of the ICP updates by all the above-mentioned means, excluding the provider portal.

Element D. Interdisciplinary Care Team (ICT) - Overview

All D-SNP members are managed by an interdisciplinary care team that helps them remain in the least restrictive care setting. Several other programs are in place to assist D-SNP members who are at risk:

- Home tele-monitoring for members with specific conditions
  - Daily reports are monitored by the member's ordering provider
  - Care Coordinators work with members and providers to avoid hospitalizations
- Post-Hospitalization Program
  - Follow-up after discharge and/or emergency room visit
- Complex case management
  - For members with frequent ER use and/or recurrent readmissions
  - Increased care management intensity to help prevent relapse
- House calls
  - Practitioners visit members who have physical, mental or functional impairments that precludes them from visiting their PCP
- Medication therapy management
  - Pharmacist participates in member's ICT
- Diet and nutrition
  - Nutritional counseling
- Behavioral health services
- End-of-life support services
- Social work support
- Home and community-based services partnerships
- Transition of Care

1. How the organization determines the composition of the ICT membership.
2. How the roles and responsibilities of the ICT members (including beneficiaries and/or caregivers) contribute to the development and implementation of an effective interdisciplinary care process.

At a minimum, the ICT consists of the member, any person the member authorizes, the member's PCP and the Optima Health Care Coordinator. Additional participants are included based on the needs, preferences, and choices of the member, and could include, but are not limited to, any or all of the following participants as appropriate to address specific needs:

- Caregiver(s)
- Medical Director
- Dietitian
- Pharmacist
- Behavioral health specialist (example licensed clinical social worker or licensed professional counselor)
- Social worker
- LTSS providers (including the RN supervisor of the provider agency for Medicaid Technical Assistance Waiver participants, service facilitator, adult day health

care center staff, nursing facility (NF) staff, etc.)
- Community Service Board Targeted Case Manager (TCM), and
- Care Coordinators/managers from other involved insurers (for example, if the member's MLTSS provider is not our D-SNP).

The member or authorized representative has a voice in selecting other formal or informal supports, service providers or individuals they wish to join their ICT. The member is an active participant in selecting and working alongside ICT participants. The ICT membership remains fluid, with changes made based on the member's status, needs, and requests, and is documented in Symphony under the "Care Team" tab.

The role of the ICT is to determine each member's goals and needs to:

- Coordinate member care
- Identify problems and anticipate crises/adverse events
- Educate members about their conditions and medications
- Coach members to use their individualized care plan
- Prepare members, or caregivers, for provider visits
- Refer members to community resources
- Manage transitions
- Identify problems that could cause transitions
- Try to prevent unplanned transitions
- Coordinate Medicare and Medicaid benefits for members
- Identify and assist members with changes in their Medicaid eligibility

During the ICT meeting, the Care Coordinator leads a person-centered approach to the ICP development, taking into account the available MLTSS services and other community resources, providing adequate information and data to assist the member and ICT participants in making informed decisions and choices. To accommodate the member and other participants, the ICT meeting can be face-to-face or telephonically using conference call or WebEx technology. The Care Coordinator documents the ICP proceedings within Symphony. The ICT participants are instructed on how to access the ICP via the Optima Health member or provider portal. Hard copies of the ICP are also available.

The table below depicts an example of ICT membership, and an overview of roles and activities to support the development of the ICP:

ICT MEMBERSHIP	ROLES AND ACTIVITIES
Member or authorized representative	• Chooses PCP at Enrollment • Participates in completion of HRA • Participates in ICP development • Participates in ICT meetings • Suggests other participants for ICT inclusion
Primary Care Physician	• Responsible for clinical and medical management of the individual's care • Provides primary care and coordination of specialty care • Provides assessment of medical and psychosocial status • Collaborates in ICT to develop ICP
Care Coordinator	• Assesses individual • Develops ICP with input from other members of the ICT • Implements actions on ICP • Educates individual/caregiver on health needs and chronic disease mgmt. • Coordinates services for the individual • Evaluates and updates the ICP at regular intervals • Serves as the single point of contact for all members of the ICT • Update ICT members as the ICP evolves • Works on Gap Closures/HEDIS measures
Care Coordinator Technician	• Assists with the coordination of services • Implements non-clinical services of the ICP such as scheduling appointments and arranging transportation
Social Worker or LMHP and/or Housing Specialist	• Contributes to ICT as a social resource specialist • Facilitates solutions for social resource requirements such as assisting with housing needs
Outreach coordinator	• May conduct an initial screening of members • Assists in locating members by phone or face-to-face to engage them in services
Behavioral Health Specialist or Targeted Case Manager	• Provides ongoing support for psychosocial/behavioral health assessment and recommendations • Contributes to the ICT as a resource for behavioral health needs for those with SMI, SED, SUD, and ID • Works with the member and ICT to implement the ICP and to overcome barriers
Medical Director	• Collaborates in ICT and ICP development/revision • Reviews medical necessity of clinical requests
Pharmacist	• Contributes to the ICT as a resource specialist for pharmacy • Assesses prescription drug utilization and trend for over/underutilization • Provides physician consultation involving pharmaceutical management • Identifies medication conflicts
Supervisor for Agency or Staff at NF	• Provide info about health status • Care management and plans

3. How ICT members contribute to improving the health status of SNP beneficiaries.

The goal is to fully integrate the member, caregiver, and all appropriate service providers about the ICT activities to administer the most comprehensive ICP.

The member and/or the member's designated representative receive an explanation of the purpose of the ICT and are encouraged to participate in each ICT meeting. If the member does not answer multiple phone call attempts to participate in an upcoming meeting, the Care Coordinator may engage an outreach coordinator (whose role is to find, engage, and connect individuals with needed healthcare, care coordination, and related social services in their communities) to go to the residence on multiple occasions, at different times of the day, to reach the member. For all members with a known cognitive deficit and unable to make determinations regarding their care, a designated representative is included to participate.

The Care Coordinator is flexible in arranging logistics for the ICT meeting, to accommodate the member's needs and preferences, thereby facilitating and enabling active participation by the member and/or their designated representative.

Accommodations are made as to the method and location of the ICT meeting. This may include a group conference call, three-way call, a face-to-face meeting in their place of residence, at a physician office, in a hospital conference room, Optima Health office, or other mutually agreeable location. Transportation is arranged for the member as necessary and feasible.

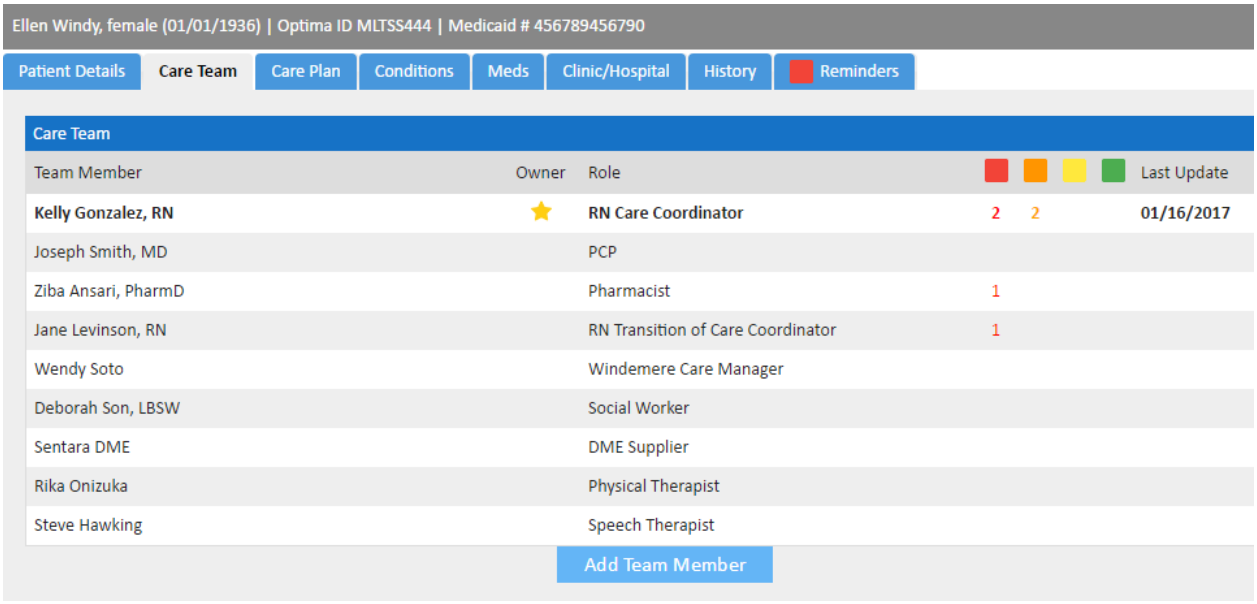
The Care Coordinator also enables participation in ICT meetings by making use of Optima Health/Sentara's Language Access Network (LAN) services as necessary, to provide communication assistance for those with special communication needs (e.g. blind, deaf, hard of hearing, limited English proficiency, and non-English speaking).

If the member chooses not to participate in an ICT meeting or is physically unable to do so due to health or other issues, and wants the ICT to meet in his/her absence, the Care Coordinator follows up with the member after the meeting to inform him/her of any updates and explain how they can access and sign off on the ICP.

Optima Health has developed orientation and reference materials about the ICT structure and team roles and responsibilities. The Care Coordinator educates the member and other ICT participants at the beginning of the ICT process and ongoing when ICT participants are added/changed over time. The material also describes the specific ICT activities, including the projected timeframes for ICP development, revision due to a change in condition, and ongoing/periodic maintenance. An example of a scenario prompting a change in the composition of an ICT follows:

After we conduct an assessment with a 35-year-old male, we discover he has not been attending his behavioral health appointments, when he had been previously. The Care Coordinator convenes the ICT, adding a behavioral health specialist and the Targeted Care Manager (TCM). Other team members would include the member, Care Coordinator, PCP, behavioral health provider, and designated family members or caregivers. The ICT would work together to identify barriers to attend behavioral health appointments and provide resources and accommodations to overcome identified barriers. A revised ICP would be created and shared with the participants.

The following is a screenshot from "Care Team" tab in Symphony, demonstrating an example of potential ICT members for a member. ICT participants are easily identifiable for Care Coordinators, so when ICT meetings need to be convened, the Care Coordinator can reach out to the ICT members who are listed, and allow them to become engaged in the member's care.



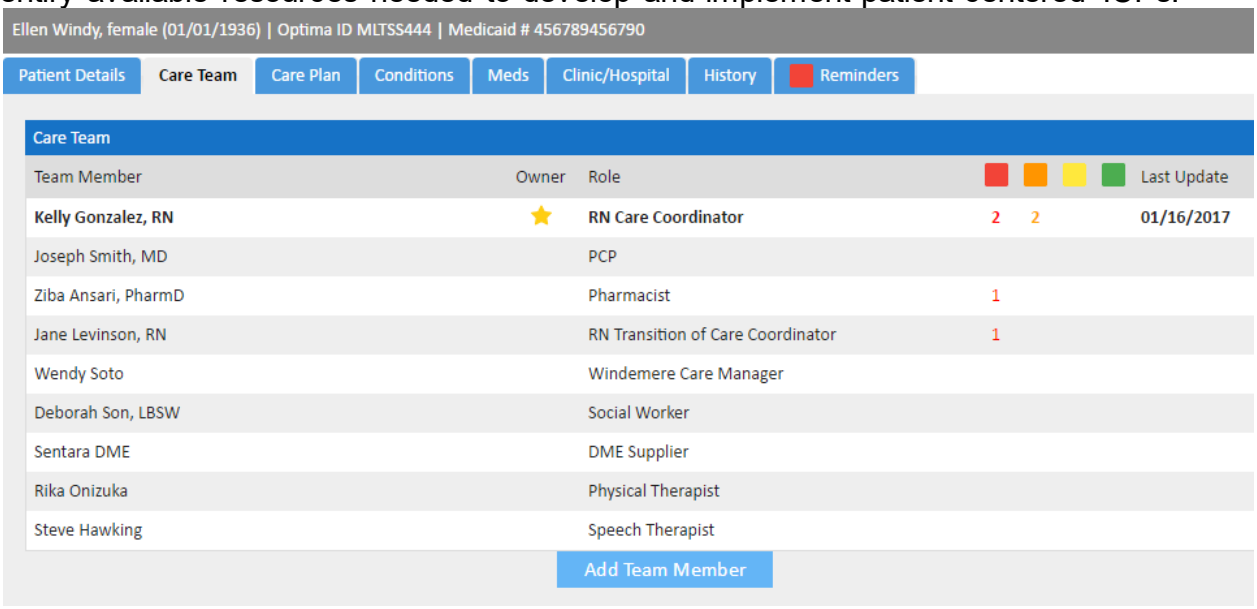
The Care Coordinator either arranges to attend external meetings in person or by telephone, invites key personnel from other existing ICTs to become part of the Optima Health ICT, or follows up with a contact at the designated entity after their meetings, to capture pertinent information useful to their assigned members' ICP.

After the initial screening and/or HRA, as the primary facilitator for managing a member's care and the Care Coordinator knows where the member resides and what additional services the member is receiving. The Care Coordinator asks all service providers such as Nursing Facilities Adult Day Health Care Programs (ADHCs) and CSBs if there are regularly scheduled or periodic ICT meetings, and noting them in the care team notes in Symphony. Ideally, the Optima Health Care Coordinator attends and participates in other provider conducted ICT meetings, but can alternatively invite those Care Coordinators to attend the Optima Health ICT.

The Care Coordinator either arranges to attend external meetings in person or by telephone, invites key personnel from other existing ICTs to become part of the Optima Health ICT, or follows up with a contact at the designated entity after their meetings, to capture pertinent information useful to their assigned members' ICP.

All participants are called upon to remain actively engaged in the ICT meeting. As part of the case review, the Care Coordinator presents a brief overview of the most current assessment, ICP, opportunities, and barriers. The ICT reviews the current assessment, ICP, goals, and progress toward goals. The ICT uses evidenced-based guidelines to assess progress to goals, and makes recommendations for modification to the ICP. The ICP is available on the member and provider portals and faxed to other service providers as necessary. To manage changes on a continuous basis, the ICP and ICT are updated at least annually, and with any significant change in condition.

The Care Coordinator utilizes various methods to gather pertinent information and identify available resources needed to develop and implement patient-centered ICPs.



Methods include, but are limited to, the following: face-to-face member interviews/HRAs, family/caregiver interviews, and when appropriate, consultations with Primary Care Physicians (PCPs), specialists, and other involved providers. Medical claims and pharmacy data are also incorporated into the research.

To determine categories of risk, the HRAs are part of an enrollment and a risk stratification process, which forms the basis of an engagement strategy, setting methods and frequency of contacts. The contacts with the member and others identified on the ICT focus on providing necessary interventions and resources to make progress on the ICP and ensure member needs are met.

Having a well-rounded approach to health care can better identify the underlying health issues as opposed to simply treating the symptoms. For this and other reasons, this Care Coordinator model utilizes an interdisciplinary, evidenced-based approach to enhance the clinical process to meet the needs of D-SNP members. On-going training and accessible resources regarding evidence-based clinical practice guidelines (EBCPG) are provided to care coordination staff. Clinical Care Team Coordinators monitor the use of EBCPG through individual and group supervision and conduct quarterly chart audits. The use of EBCPGs combined with the integration of the best available resources can lead to improvements in their assigned member outcomes.

Outcomes are routinely measured and compared to Optima Health goals as well as national and regional benchmarks. The outcomes are reviewed through concurrent Utilization Review processes and at relevant Optima Health committee meetings.

4. How the SNP's communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange.

The Care Coordinator provides leadership to the Interdisciplinary Care Team (ICT) in the development of an ICP, based upon the findings of the initial screening and/or the HRA, resulting in a list of proposed interventions in Symphony, the care coordination system. Symphony extracts from the assessment a member's strengths and barriers for the ICP, for example, if the Care Coordinator notes unstable housing as an issue, the system auto-populates a goal for stable housing, with suggested interventions and actions for the Care Coordinator to address toward resolution of the problem. The Care Coordinator then adopts or customizes the system recommendations.

The initial ICP and any revisions are communicated to the member and ICT verbally, during ICT meetings, during visits and phone calls with members, and are made

available in writing to all parties. The member or a designated representative receives a copy during Care Coordinator visits, and can also download a copy on the member portal. Providers are supplied with an initial ICP and any updates by fax, secure encrypted email, secure FTP Internet site (provider portal), or by mail. Other members of the ICT can receive a copy of the ICP by all the above-mentioned means, excluding the provider portal.

Special communication needs are identified with every member or representative (as allowed under state law) during the initial contact with Optima Health (e.g. Member Services, Clinical Care Services, the Consumer Call Center, and the Member Outreach Team). Communication needs are documented in the member profile, along with the communication method identified/named as preferred by the member.

The Optima Health Care Coordinators are trained in culturally competent care and are attentive to any cultural needs the member may have and incorporate these elements when building and communicating the ICP. To accommodate the communication needs of members with communication impairments, Optima Health accesses the Sentara Language Line (SLL), described below, and free of charge to the member, whenever necessary, SLL provides communication services 24 hours a day and 365 days a year to members (and representatives, in appropriate circumstances) with special communication needs. Optima Health does not utilize staff members to serve as interpreters unless they are approved through Human Resources as qualified/certified to provide such services.

SLL offers the following communication services for Optima Health:

1. Telephonic/OPI (Optimal Phone Interpreters) Interpretation for LEP (Limited English Proficiency);
2. On-Site interpreter or CART services On-Site Interpreters for ASL (American Sign Language) and LEP;
3. Written Translations of Optima Health's Documents (including Braille).

For members who have intellectual or developmental disabilities, Care Coordinators develop and communicate the ICP with a member's designated representative, caregivers, or family members.

Each ICT Meeting is documented in Symphony. The ICT reviews and updates the ICP, with notes and changes documented within the Care Plan in Symphony. The full Care Plan is available to the Member and the Provider through the Optima Health Portals. The Portal is updated daily. Feedback routed back to the Care Coordinator for review and inclusion and includes areas of free text for the Member or Provider to enter feedback.

The following is an example of an ICT meeting documented in Symphony.

Cindy Test, female (01/01/1991) | Optima ID# 11111
Encounter Type
Type of Encounter: Provider Practice
Attended: Member Family Member Pharmacist PMP
Prior to Contacting Patient
Current Risk Status: TOC Program - HIGH
Next Step: Assessment
Home Phone: N/A | Cell: 5569987
Notes
ICT meeting at Dr. Smith's office. Member, husband, Jane Pharmacist RPH, Dr. Smith and myself met to discuss Med Rec and Adherence problems. Care Plan updated with new Med Rec and recommendations for electronic pill box with automated reminders.
Summary last
Schedule Appointment (f/u to MCT), Cindy Colligan, RN Team Notification, Importance: Critical, Date Due: 01/17/17
Problems
Knowledge Deficit
Adherence to Treatment Plan
Inappropriate Utilization

Updates made to the ICP, are then refreshed in the Portal, to ensure all members of the ICT are working towards the same goals with the same information. A hard copy is also provided to involved/authorized person, upon request.

OPPORTUNITY: ADHERENCE TO THE TREATMENT PLAN WHICH CAN BE IMPACTED BY CARE COORDINATION
Status: Ongoing
Interventions: Assess current knowledge of condition Educate on importance of Treatment Plan Educate member on resources
Actions: Obtain medication or equipment Seek and obtain needed resources Demonstrate ability to follow treatment plan
Goal Notes: 1/12/17 needs appt for new order. CLC 1/15/17 Appt scheduled 1/16/17 with PMP, obtain current Treatment Plan and testing schedule. CLC 1/17/17 Reviewed Treatment Plan from PMP, started Med Box to help member remember medication on time. Medication Reconciliation Complete by Pharmacist, Education materials reviewed with member. CLC

Element E. Care Transition Protocols

1. The process for coordinating transitions

Through dedicated Transition Care Coordinators (TCCs) the Transitional Care Program (TCP) provides one-on-one, intensive, short-term support and guidance to members who are transitioning from nursing facilities, hospitals, inpatient rehabilitation, or other institutional care settings, or into the community. Transition Care Coordinators possess the same qualifications as the Care Coordinators, however do not carry an assigned caseload. To capture a member's goals, preferences and ability to transition safely and successfully to the community, the Transition Care Coordinator also works closely with nursing facilities to incorporate elements of the Minimum Data Set (MDS) tool, specifically within section Q, into assessments. Transition coordination services include, but are not limited to:

- the development of a transition plan;
- the provision of information about services that may be needed, in accordance with the timeframe specified by federal law, prior to the discharge date, during and after transition;
- the coordination of community-based services with the Care Coordinator;
- linkage to services needed prior to transition, such as, housing, peer counseling, budget management training, and transportation;
- ongoing documentation and communication via ICT meetings, and ICP updates posted to the Optima Portal;
- securing necessary authorizations to assure continuity of care after transition; and the provision of ongoing education and support of self-management activities for up to 12 months after discharge date.

2. Personnel responsible for coordination efforts.

Optima Health's Transitional Care Program (TCP) is based on the Coleman Care Transition Model. It sets forth processes and procedures for follow up with discharged members to meaningfully enhance the care transition process, and to coordinate service planning and delivery among the institution discharge planner(s), the Transition Care Coordinators, the Care Coordinator, the member, and the ICT.

3. Description of coordination between settings during a care transition.

Seamless transitions of D-SNP members between care settings is supported by:

- Notifying the member's PCP of the transition
- Sharing the member's ICP with the PCP, the hospitalist, the facility, facility based case managers, and the member or caregiver (where applicable)
- Engaging the member prior to a planned transition to provide educational materials and answer questions related to the upcoming transition
    - Ongoing, proactive interactions with the member/caregiver to monitor

the transition plan, provide support and education, and make necessary adjustments.

4. How beneficiaries have access to personal health information to facilitate communication with providers.
5. Education provided to members/caregivers to manage conditions and avoid transitions.
6. Process used to notify members/caregivers of staff assigned to support member through transitions.

The Transition model includes the Post-Hospitalization Program, which includes phone calls to members after they are discharged to home. Members receive hospital follow-up calls within two-three days and again at seven days post discharge, as well as calls after an Emergency Department visit.

These calls focus on addressing immediate needs identified by the member or their caregiver. The specially trained team:

- helps the member understand discharge diagnosis and instructions
- facilitates follow-up appointments and other services to promote continuity of care
- assists with needed home health and equipment
- assists with identified social determinants of health
- resolves barriers to obtaining and safely taking medications
- educates the member on new or continuing medical conditions

After immediate needs are addressed, a hand-off to the member's Care Coordinator or the dedicated Transition Care Coordinator (for members with complex discharge needs) occurs, for members who require additional assistance.

For members not participating in follow-up calls, or whose complex needs require additional management (such as members transitioning to specialty facilities such as Long Term Acute Care Hospitals or inpatient psychiatric care centers), the Transition Care Coordinator works in conjunction with the member's assigned Care Coordinator to identify and resolve any transition issues.

In either scenario, the Optima Health Care Coordination team communicates with all members of the ICT, including updating and distributing the ICP.

3. Provider Network

A. Specialized Expertise

Regulations at 42 CFR§422.152(g)(2)(vi) require SNPs to demonstrate that the provider network has specialized clinical expertise in delivery of care to beneficiaries.

- Provide a complete and detailed description of the specialized expertise available to SNP beneficiaries in the SNP provider network that corresponds to the SNP population identified in MOC Element I.

The configuration of the SNP provider network is developed based upon the needs of the SNP's most vulnerable members. Member information utilized to frame the configuration of the network includes, but is not limited to, monthly DMAS enrollment files, DMAS medical transition data, referrals from the member's Interdisciplinary Care Team (ICT), community agencies, reports, health risk screening/health risk assessment, predictive modeling, utilization/pharmacy reports, and real-time utilization data.

The SNP provider network is continuously evaluated to assure that the SNP beneficiaries' needs are addressed, as well as to promote health literacy and self-management. Demographic, claims, authorization, and outcomes data are utilized to map the beneficiaries to the contracted provider network. Out-of-network and out-of-area authorizations are monitored to identify service delivery gaps, match service needs to the population, and to target providers for contracting opportunities. Access and availability audits are also conducted.

The needs of the identified populations guide the network development and adequacy measurement initiatives. Geo-mapping is routinely performed to identify service delivery gaps and available providers in each region. The Optima Health network development staff continually seek and recruit providers identified through this assessment process, and compile ongoing network adequacy reports.

To support continuity, in circumstances when a provider is not contracted, out-of-network authorizations and/or single case agreements may be approved. Out-of-network providers are still required to comply with limited credentialing, as well as quality, utilization management, and billing standards. If frequent out-of-network authorizations are made for a particular provider or type of provider, efforts are made to fully credential and contract with these identified provider types.

Target Population, as detailed in MOC Section 1, summarized below:
A snapshot of the Special Needs Population includes:

- average age 70 and older
- 68 % female
- multiple chronic co-morbidities (greater than five)

- an average of over six medications
- require assistance with two or more activities of daily living
- almost half have dementia
- 30% have major depressive disorders
- 15% have protein-calorie malnutrition

The target population includes the EDCD waiver recipients, requiring waiver services that may include any of the following: adult day healthcare, personal and respite care (both agency and consumer-directed services), private duty nursing, personal response systems, medication monitoring, and transition coordination services. Some of the individuals reside in assisted living and long-term care facilities. Also included are individuals with intellectual and/or developmental disabilities, with cognitive or memory problems often as the result of a traumatic brain injury or dementia; with physical as well as sensory disabilities, and with serious or persistent mental illness

The target population includes individuals with specific chronic illnesses. More than half of all dual-eligible individuals have three or more chronic conditions as compared to non-dual-eligible, and 50% also have a cognitive or mental impairment versus non-dual-eligible. A larger share of dual-eligible individuals need help with activities of daily living, such as dressing or feeding.

Optima Health has identified the following sixteen conditions to be the most prevalent among the targeted population (not listed in order of prevalence):

1. chronic alcohol and other drug dependence
2. autoimmune disorders (including, but not limited to, polyarthritis, polymyalgiarheumatica, polymyositis, and rheumatoid arthritis)
3. systemic lupus (erythematosus-culled out as a category from autoimmune, due to prevalence)
4. cancer (excluding pre-cancer conditions or in-situ status)
5. cardiovascular disorders including cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorder
6. chronic heart failure
7. dementia
8. diabetes mellitus
9. end-stage renal disease requiring dialysis
10. severe hematologic disorders including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait), and chronic venous thromboembolic disorder
11. HIV/AIDS
12. chronic lung disorders, such as asthma, chronic bronchitis, emphysema, pulmonary fibrosis, and pulmonary hypertension
13. chronic and disabling mental health conditions (bipolar disorders, major-depressive disorders, paranoid disorders, schizophrenia, and schizoaffective disorder)

depressive disorders, paranoid disorders, schizophrenia, and schizoaffective disorder)

14. neurologic disorders (amyotrophic lateral sclerosis (ALS), epilepsy, extensive paralysis – hemiplegia, quadriplegia, paraplegia, monoplegia, and Huntington's disease)
15. Multiple sclerosis, Parkinson's disease, polyneuropathy, spinal stenosis, stroke-related neurologic deficit
16. stroke

Ongoing analysis of the members enrolled with Optima Health ensures that this listing is updated accordingly and used to assure that the provider panel meets the needs of the most vulnerable conditions.

Additionally, the scope of specialized services is identified through the committee process. This includes providers across the continuum\who offer services related to medical management and disease specific conditions such as, but not limited to:

- geriatric internal medicine
- endocrinology
- cardiology
- neurology
- oncology
- palliative care
- hospice
- long-term care facilities (including Assisted Living (ALFs), and skilled nursing facilities (SNFs))
- waiver providers (PERS, Adult Day Care, etc.)
- pulmonology
- nephrology
- urology
- rheumatology
- infectious disease
- behavioral health

Specialty facilities, such as Lake Taylor Hospital, are presently Optima Health contracted providers.

Optima Health recognizes that the SNP beneficiaries also require inclusion of both typical and atypical providers with expertise in supporting the psychosocial, functional, and end of life challenges.

Ongoing Oversight

Optima Health network management and quality improvement teams work closely together in regards to physician complaints, physician satisfaction, office site reviews, and network adequacy. A contract manager reports practitioner activities annually to the Quality Improvement Committee. The Physician Advisory Council also reviews data within their respective scope and reports through the Quality Improvement Committee.

- Explain how the SNP oversees its provider network facilities and ensures its providers are actively licensed and competent (e.g., confirmation of applicable board certification) to provide specialized healthcare services to SNP beneficiaries. Specialized expertise may include, but is not limited to: internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists, other.

The Optima Health Network Management Department is responsible for the development and maintenance of the provider network. As described above Geo-mapping reports and network penetration reports are routinely used to measure network relevance and access to the populations served.

Through the credentialing process and monthly checks of the Excluded Providers database, Optima Health ensures providers are actively licensed and competent to provide specialized healthcare services to SNP beneficiaries. All providers, including specialists, are credentialed before they are included in the Optima Health network.

Credentialing is conducted through a prescribed review process that includes review by a Medical Director and full peer review of files. At the time of the provider's initial request to participate in the Optima Health network and every 36 months thereafter, Optima Health reviews their education, experience, license/certification, and credentials. The application is compared to the primary verification of the state licensure, claims history, board certification, CMS excluded provider list, and/or National Provider Data Bank (NPDB). The Optima Health credentialing requirements meet NCQA Standards, and can be reviewed in the Optima Health Provider Manual. Copies of the Optima Health standards, as well as all policies and procedures, are available upon request.

Data in the provider's application varies by provider type. This may include the following:

- par hospital admission privilege including cross coverage for solo providers by a participating provider, and/or listing of provider group coverage for providers within group
- professional liability insurance and previous insurance company(s)
- current, unencumbered Virginia, TN, WV, KY and/or NC medical license and all other past state licenses noting any sanctions
- current NTIS DEA
- degree of education, and highest level of internship/residency/fellowships,
- specialty board certification/eligibility
- ECFMG (if applicable)

- current curriculum vitae
- discrepancies on CV and/or listed on application
- results of query of NPDB and HIPDB
- primary source verification for malpractice claims history
    - If a provider does not have a clean file, and has licensure issues, NPDB issues and/or malpractice suits, two references are requested
- OIG Medicare/Medicaid Sanction Report for each provider, noting any sanctions against a Provider,
- Opt-Out List Form for Medicare to be verified by Network Management with change form

Ongoing Oversight

Monthly checks of contracted providers against the FEHDB Debarred/Suspended Providers database are conducted. Providers appearing on Medicare, Medicaid, or FEHBP (CP100) debarred or excluded list) are not permitted to participate in the Optima Health network. Monthly, the Credentials Analyst runs the OIG Sanction report query through ECHO, a software tool that links to the OIG database and screens all providers against the OIG. Also on a monthly basis, the Credentialing Manager audits the listing sent for EPLS (Excluded Parties List System) and reviews against the network database.

Site visits are conducted in the event that a service complaint is received, after review by the Medical Director. Results of the visit are forwarded to the Credentialing Department.

In limited circumstances where credentialing responsibilities are delegated, audits by Optima health are completed at least annually. During the audit, the compliance with credentialing procedures are reviewed, based on a random sampling of files.

- Describe how providers collaborate with the ICT (MOC Element 20) and the beneficiary, contribute to the ICP (MOC Element 2C) and ensure the delivery of necessary specialized services. For example, describe: how providers communicate SNP beneficiaries' care needs to the ICT and other stakeholders; how specialized services are delivered to the SNP beneficiary in a timely and effective way; and how reports regarding services rendered are shared with the ICT and how relevant information is incorporated into the ICP.

The ICT collaborates to address beneficiary issues in a holistic, person-centered approach. The Care Coordinator functions as the leader of the ICT. At a minimum, the ICT will consist of the member (beneficiary), any person the member authorizes, the member's PCP, and the Optima Health Care Coordinator. Additional participants are added based on the needs, preferences, and requests of the member This may include:

- caregiver

- medical director
- dietitian
- pharmacist
- behavioral health specialist
- social worker
- housing specialist
- LTSS providers (including the RN supervisor of the provider agency for Medicaid Tech Waiver participants, services facilitator, adult day health care center staff, nursing facility staff)
- Community Service Board Targeted Case Manager (TCM)
- Care Coordinators/managers from other involved insurers (for example, if the member's MLTSS provider is not our D-SNP).

Providers, as members of the ICT, are encouraged to contribute to the ICP process by communicating information before, during and after the ICT convenes.

The member or authorized representative has a voice in selecting other formal or informal service providers or individuals they wish to join their ICT. The member is an active participant in selecting and working alongside ICT participants. The ICT membership remains fluid, with changes made based on the member's status, needs and requests, and is documented in Symphony under the "Care Team" tab.

The strategies that Optima Health use help to engage and solicit input from the various ICT participants includes, but is not limited to:

- promoting transparency of information in an understandable fashion,
- timely distribution of information needed to support the process (in formats preferred by the recipients)
- sharing results from the HRA, risk stratification, claims, and authorization histories at the ICT meeting
- soliciting input from all involved ICT members
- utilizing risk stratification to guide the Individualized Care Plan needs

After the initial screening and/or HRA, as the primary facilitator for managing a member's care, the Care Coordinator knows where the member resides and what additional services the member receives. The Care Coordinator asks all service providers if there are regularly scheduled or periodic ICT. The Care Coordinator either arranges to attend external provider based ICT meetings in person or by telephone. Or, invites key personnel from other existing ICTs to become part of the Optima Health ICT. Also, the Care Coordinator may follow-up with a contact at the designated entity after their meetings to capture pertinent information useful to their assigned members' ICP.

During the ICT meeting, the Care Coordinator leads the team through a person-centered approach to the ICP development; soliciting input from the member, the

member's family/caregivers, and treating/supporting providers, while taking into account the available clinical, behavioral, MLTSS services, and other community resources. The Care Coordinator does this while providing adequate information and data to assist the member and ICT participants in making informed decisions and

choices. ICT meetings and associated ICP updates are conducted at enrollment, as required by eligibility category, when a change in condition/trigger event occurs, and at least annually. Any member of the ICT can request the team convene to address any member situation, and adjust the ICP.

Providers, as members of the ICT, are encouraged to contribute to the ICP process by communicating information before, during, and after the ICT convenes. Information and feedback about the ICP can be shared by phone or through secure email/fax/call to the Care Coordinator. Care Coordinators also can present information on behalf of those providers who are unable to attend to the ICT.

To accommodate the member and other participants, the ICT meeting can be face-to-face or telephonically, using conference call or WebEx technology.

In addition, to promote provider participation in the ICT process, Optima Health utilizes the following:

- contract language/provider manual directions, stipulating the ICT requirement for all providers identified pertinent to the member's ICT, and/or requested by the member
- scheduling ICT meetings during appointments at the provider site, or during times when the member is already present (such as Adult Day Care sites)
- conducting ICT meeting during routine provider care management meetings (such as quarterly NF Care Conferences)
- soliciting provider input at all phases of ICT process, before/during/after ICT meetings

The Care Coordinator creates and documents the ICP proceedings within the Symphony Care Management system. The ICT participants are instructed on how to access the ICP via the secure Optima Health member portal or provider portal. Hard copies of the ICP are also available. After ICT review, the ICP is formally implemented. The Care Coordinator is responsible for assuring that care/service arrangements are made (including any specialized care), necessary authorizations are secured, and any obstacles to implementing the plan are addressed and communicated to the providers as appropriate.

B. Use of Clinical Practice Guidelines & Care Transitions

Regulations at 42 CFR §422.101 (f)(2)(iii)-(v);42 CFR§422.152(g)(2)(ix) require SNPs to demonstrate the use of clinical practice guidelines and care transition protocols.

1. Monitoring how providers utilize CPG and nationally–recognized protocols appropriately

Evidence Based Practice Guidelines- General

Optima Health has developed policies and procedures and a committee review structure governing the selection, evaluation, and deployment of evidence based practice guidelines. Providers are contractually required to comply with clinical guidelines adopted and promulgated by Optima Health. Provider must also adhere to nationally recognized standards of care.

Optima Health primarily uses Milliman Care Guidelines (MCG), DMAS's service authorization criteria, American Society for Addiction Medicine (ASAM), Addiction and Recovery Treatment Services (ARTS), Coleman's Transitions Model or other national standards in making medical necessity determinations. In addition, proprietary guidelines are developed and utilized to augment these nationally accepted standards.

Plan-wide changes in guidelines and policies are communicated to all departments when finalized, posted to the Optima Health website, and highlighted quarterly in provider and member newsletters/communications.

Optima Health's medical/clinical necessity criteria is no more restrictive than the Medicaid FFS Medicaid program criteria, including quantitative and non-quantitative treatment limits, as indicated in State and/or Federal statutes and regulations, the State Plan, and other State policy manuals.

Clinical practice guidelines and protocols are evaluated through the Optima Health Committee structure (explained below), initially upon adoption and at a minimum of every two years (or more frequently if indicated). Upon completion of the process:

- a final copy of the policy or guideline is placed in the Medical Care Services Medical Policies section of Wavenet (the Sentara/Optima Health online training portal, and education management system)
- appropriate departments are notified of the changes
- codes are updated in the system
- fees are attached to the codes
- notices are distributed to network providers through email messages, and banner messaging on the provider portal

Provider Education of Guidelines

Providers may access the Optima Health clinical guidelines through the website. The Provider Manual, provider newsletters, and Network Educators also serve as resources to communicate to providers the availability of guidelines, and to outline compliance expectations.

Provider and Network Management maintain clinical Guidelines and Model of Care class/training completion records. Also, a monthly report is generated noting which providers and staff have completed mandatory training, and which have not.

- providers will be assigned this training during mandatory orientation within 30 days of contract
- providers who have not completed mandatory training within the make-up period offered will be identified to the Network Management and Credentialing Departments, and the following interventions may be pursued:
  - Network Educators may schedule an individual training
  - a Medical Director may contact the provider
  - a schedule of sessions to complete training may be provided
  - a temporary suspension from the network may be considered until the training is completed
  - member assignment/referral to the provider may be suspended
  - provider participation contract may not be renewed at re-credentialing

NOTE: Actions taken regarding temporary suspension from the network, contract revocation, or non-renewal may be reported to the NPDB. Every effort will be made to assure training is completed before consideration of such measures.

Evaluation of guideline use

Compliance with clinical practice guidelines and outcomes are contractually required, and are routinely measured and compared to Optima Health goals, national benchmarks, and regional benchmarks. Outcomes are reported and reviewed at relevant Optima Health committee meetings, including the Quality Improvement Committee.

Data to support the evaluation process is primarily derived from the ongoing Utilization Review process (which includes claims and authorization reviews and monitoring over and underutilization). These utilization rates are compared to national and proprietary guidelines. Monthly reports are generated against protocols to identify gaps in care rendered to members, but to also identify any provider associated patterns that need to be addressed through education or sanction. The same data is used over time to support committee evaluation, described above, to identify protocols that are obsolete and need update or retirement; and to highlight opportunities to develop new ones.

Data is also gathered through the Quality Improvement process, which entails focused audits of compliance to protocols/guidelines. Focused audits can be conducted through claims/authorization reports, manual chart reviews, and other compliance

reports.

Identification and Development of New Guidelines

The Optima Health Care Coordination team continually monitors the delivery of services to members to determine to what extent the guidelines available are relevant to the scope of services the population requires. ICP components are reviewed to ascertain the guidelines most often applied to associated authorizations, and conversely, which ICP components are forwarded to exception reviews. When a requested service is repeatedly subject to exception reviews, it is considered a trigger to modify existing guidelines/protocols, or develop new ones to assure authorization and care coordination procedures are consistently utilized. The evaluation process described below is initiated. Providers may submit a request for a Technology Review for services not currently associated with a practice guideline, by submitting a request for pre-authorization.

The request is forwarded to the RN Technology Review Coordinator for Technology Review and the following is completed:

- review of information
- review of the information as outlined in the procedure
- review at the Medical Directors meeting by assigned physician
- review of benefits
- review of codes
- develop policy and address review in minutes
- approval by committee
- placed on quarterly release

In addition, changes to guidelines and protocols dictated from external sources, such as accreditation bodies, national guideline vendors, State/Federal agencies, benefits configurations, and professional organizations are monitored. Necessary changes are made to existing policies or adopted for new policies.

- Define any challenges encountered overseeing patients with complex healthcare needs where clinical practice guidelines and nationally-recognized protocols may need to be modified to fit the unique needs of vulnerable SNP beneficiaries. Provide details regarding how these decisions are made, incorporated into the ICP (MOC Element 2C), communicated with the JCT (MOC Element 20) and acted upon.

Complexity of healthcare gaps present challenges because the solutions to addressing them are often creative and do not fit into existing protocols. The Individualized Care Plan (ICP) process is member-focused, considering the unique situation of each member. Frequently, available protocols are not applicable or only address a portion of the existing challenges.

The ICP/ICT process supports the exploration of creative solutions and makes, along with the Medical Director, the determinations to implement benefits, which do not correspond to protocols. In situations when the existing guidelines are not sufficient, comparable protocols are utilized to guide the ICT's ICP development and associated authorizations. In total absence of relevant guidelines, the ICT makes its best attempt at determining appropriateness. The Optima Health Medical Director is accountable to assure that the exception process is objective and uniformly applied.

The Care Coordination team is also empowered identify opportunities to address gaps in care and services to members. In many circumstances, the Care Coordination team is permitted to authorize components of the Individualized Care Plan, as approved by the Interdisciplinary Care Team. As described above, patterns of exception requests for care and services generated through the ICP/ICT process may trigger the guideline development process.

A common example of an exception is genetic testing. Advances in genetic testing and new screenings are released faster than criteria are available. In those situations, research is conducted, which includes but is not limited to: Hayes, policies of other regional carriers, and peer reviewed publications. The general criteria thresholds: impact on treatment, impact on outcomes, and impact on course of care, are also considered before rendering a determination.

- Explain how SNP providers ensure care transitions protocols are being used to maintain continuity of care for the SNP beneficiary as outlined in MOC Element 2E.

Optima Health has adopted the Coleman Transitions Model and associated protocols as the foundation of its program.

The Optima Health Care Coordinator or the Regional Transitions Coordinator is responsible for coordinating all activities related to the member during transitions. This includes performing assessments, assuring that continuity of care is maintained through authorizations, ICP maintenance, and communication of any ICP requirements. It is also the Coordinator's responsibility to assure that any activities associated with the transition and ICP are communicated to providers (and all involved parties) in a timely and clear manner. Examples specific to the Coleman model include, but are not limited to: medication reconciliation at discharge, understanding red flags that may signal a worsening in medical condition, and prompt follow-up with the member's primary care provider after hospital discharge.

In addition to soliciting the provider's input into the development of the transition/ICP through the ICT process, the Care Coordinator also assures that the plan is agreed upon by the involved providers and that they receive a copy or are aware to download

a copy of the plan from the secure provider portal. Optima Health can document distribution of the transition/ICP to any involved providers through portal access reports, fax receipts, care management notes, and mail receipts.

Historical information that includes prior service, ICPs, and authorization histories are maintained in the member's Symphony Care Management records. This information is used to assure that services in place prior to a transition are considered as part of the transition plan.

During transitions, the Regional Transitions Coordinator, Care Coordinator, or other Optima Health staff periodically consults the member and involved providers to assure that the agreed upon plan is being followed, and to reinforce any tasks and goals. In addition, claims are monitored to assure that authorizations and services identified in the transition plan are delivered.

C. MOC Training for the Provider Network

Regulations at 42 CFR§422.101(f)(2)(ii) require that SNPs conduct MOC training for their network of providers.

- Explain, in detail, how the SNP conducts initial and annual MOC training for network providers and out-of-network providers seen by beneficiaries on a routine basis. This could include, but not be limited to: printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, and availability of instructional materials via the SNP plans' website.

Optima Health understands the critical importance and need for comprehensive provider training and continual provider education. Optima Health requires initial and annual training of contracted providers. Training curriculums are designed to ensure effective and efficient delivery of quality care to Optima Health members, in adherence with governing federal and state regulations.

The Optima Health D-SNPMOC training curriculum includes the following subject areas:

- background on D-SNP Program
- D-SNP Eligibility Requirements
- eligibility Verification Process
- description of targeted populations
- D-SNP Benefits
- Care Coordination:
  - role of the Care Coordinator
  - Health Risk Assessments
  - Interdisciplinary Care Team
  - Individualized Care Plan
  - person-centered approach
- utilization management
  - service authorizations
  - transitions of care
  - continuity of care
  - out-of-network services
- performance and health outcomes measurement
- marketing and outreach process
- member rights and responsibilities
- cultural competency
- claims processing requirements
- appeals and grievances policies/procedures
- provider portal
- communication and plan contact information

Annual and ad hoc training sessions are also provided by Optima Health. These training sessions may consist of:

- updates to CMS requirements and benefits
- updates to the model of care
- Interdisciplinary Care Team (ICT) meetings
- how to prepare for ICT meetings
- engaging the enrollee/caregiver in the ICT Meeting
- annual training requirements

Initial and annual training is offered to providers through a variety of mechanisms, including webinar, individually by Network Educators, formal classes/town hall meetings, provider orientations, self-directed study (including through printed and electronic formats), and internet-based classes (through OneLink training management system). Optima Health has the ability to post training material via an unsecured website so that contracted and non-contracted providers may access it for reference, or to complete the training and return an executed attestation. For providers with valid email addresses on file, a notice can be sent to providers reminding them of deadlines to complete training, and/or to alert them that new materials are posted that require review.

When new programs are launched, Optima Health may schedule provider education sessions, at various days/times and locations, or via webinar. Notices and instructions on how to access training also may be posted on the Optima Health website, in the provider newsletter, on the provider portal, or via email notification.

The requirement to comply with training is included, as appropriate in single-case agreements, executed by non-contracted providers. Non-contracted providers who are subject to this provision are monitored in the same manner as network participants.

As practicable, training for different products will be combined to optimize the time providers spend completing the requirements. For example, information common to all programs, such as authorizations, eligibility verification, etc., is presented applicable to all populations, and information individual to each program is then presented in more detail. To support compliance with the requirement and to avoid topic duplication, initial and annual training for all products can be completed by the provider through one module.

- Describe how the SNP documents and maintains training records as evidence of MOC training for their network providers. Documentation may include, but is not limited to: copies of dated attendee lists, results of MOC competency testing, web-based attendance confirmation, electronic training records, and physician attestation of MOC training.

The Optima Health web-based training system, OneLink, seamlessly captures all data related to training, including, but not limited to: course attempts (or lack of), course completion, associated pre and post-test scores. One Link automatically generates a reminder to the provider enrolled in the course(s) for follow-up, or annual/periodic training.

Formal classes, offered routinely, require providers attending them to sign in and certificates of completion (if indicated) are not awarded unless the provider has participated in the entire training. Attendee/sign-in lists are maintained for compliance and credentialing purposes.

If a Network Educator provides training, he/she will document completion for the provider.

Providers who elect to complete Optima Health approved training through nationally accepted courses/topics (example: Cultural Competence), may earn continuing education credits, which will be accepted as evidence of completion for required training.

- Explain any challenges associated with the completion of MOC training for network providers and describe what specific actions the SNP Plan will take when the required MOC training has not been completed or is found to be deficient in some way.

Providers typically have little to no availability to participate in training. In addition, for those located in rural areas classroom based orientations can be geographically unfeasible. Recognizing this, providers are permitted a 60-day window to complete training for new program launches. Reminders that annual training is due are sent to providers a month prior and providers are permitted a 30-day window after due date to complete the training. Extensive efforts are made to assure the providers have access to multiple opportunities and modalities for training, in order to avoid non-compliance and potential sanctions.

Training requirements and availability are communicated upon launch of new programs through various mechanisms, including, but not limited to: provider newsletters, Optima Health website, secure provider portal, during Network Educator interactions, in the Provider Manual (which is referenced per Contracts), and blast email.

Provider Education staff may offer off-cycle training in classroom or one-to-one formats, or via webinar to accommodate providers deficient in training.

Strategies to engage providers includes offering training at other meetings attended by providers (such as hospital staff meetings), publishing self-study materials; webinars and enabling web-based participation/testing. Town hall meetings may be scheduled at various locations and time/dates, and one-to-one instruction may be offered. Continuing education credits may be offered to encourage provider participation.

Evidence of course completion issued by Optima Health approved educators, such as continuing education certificates, for topic such as cultural competency, may be accepted to satisfy the training requirements and void duplication of efforts.

Depending upon the mode of education delivery, recording completion of initial and annual training may be accomplished in different ways. Providers may:

- sign-in at the beginning and end of each training session
- sign an attestation of training completion, and forward to the Provider Network Management (for tracking)
- utilize an identifier (such as EIN, or provider number or one individually assigned by the trainer) to log into web-enabled training
- submit continuing education certificates from Optima Health Approved/offered educators
- sign an attestation upon completion of Network Educator sessions.

Pre-and post-test methodologies are used as appropriate and recorded as described above.

Class/training completion records are maintained by the Network Management Department and a monthly report may be generated noting which providers have completed any mandatory training, and which have not.

Providers will be assigned this training during mandatory orientation within 30 days of contract. Providers who have not completed mandatory training will be identified to the Network Management and Credentialing Department, and the following interventions may be pursued:

- Network Educators may schedule an individual training
- a Medical Director may contact the provider
- a schedule of sessions to complete training may be provided
- a temporary suspension from the network may be considered until the training is completed
- member assignment/referral to the provider may be suspended
- provider participation contract may not be renewed at re-credentialing

NOTE: Actions taken regarding temporary suspension from the network or contract revocation may be reported to the NPDB. Every effort will be made to assure training is completed before consideration of such measures.

On an ongoing basis, the education compliance rates will be monitored by the Credentialing Committee, which includes providers and Network Management staff, to evaluate the effectiveness of the training initiatives, and make recommendations for improvements.

4. MOC Quality Measurement & Performance Improvement

Element A: Quality Performance Improvement Plan

4.A.1 Describes the overall quality improvement plan and how the organization delivers or provides for appropriate services to SNP beneficiaries, based on their unique needs.

Optima Health promotes a culture of continuous improvement as an organization. The team identifies and adopts national and local best practices while remaining responsive to changing market conditions. Our continuous focus on our beneficiary-centric quality care goals allows Optima Health to meet our mission to "Improve Health Every Day".

Our Quality Improvement (QI) Program fosters data-driven decision making by recognizing and addressing opportunities for improvement. The Optima Health QI Program establishes the road map by which we achieve measurable and sustainable improvements in services delivered to our D-SNP beneficiaries.

Overall Quality Improvement Plan
Optima Health's QI organizational and program structure is fully compliant with the provisions of Medicaid Code of Federal Regulations for Managed Care 42 CFR 438, including Subparts D and E, and meets the quality management and improvement criteria of the most current National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements.

Our QI Program provides a continuous, integrated, and coordinated approach to improving the quality of health care, including physical, behavioral health, and long-term services and supports across the continuum of care for beneficiaries we serve. The Optima Health QI Program is based on the principles of Continuous Quality Improvement (CQI), focusing on implementing the Plan-Do-Study-Act (PDSA) cycle as a means to meet or exceed the minimum performance standards established by CMS, DMAS, NCQA, and/or the health plan itself.

The structure of the Model of Care (MOC) has been designed to determine if it effectively addresses beneficiaries' unique health needs. Performance goals and benchmarks are designed around the following indicators:

- improving access to and affordability of healthcare services
- improving coordination of care and service delivery
- ensuring seamless transitions of care
- monitoring appropriate utilization of services.

The purpose of the QI Program is to provide a foundation for continuous quality improvement following a MOC framework that emphasizes continual re-evaluation of organizational systems, functions, processes, measures, and activities. The program is designed to implement, monitor, evaluate, and improve processes for beneficiaries of the Medicare Dual Eligible Special Needs Plan (D-SNP). The beneficiaries that we serve are the dual eligible population, who often have complex medical conditions that may also require Managed Long Term Services and Supports (MLTSS). In addition, our beneficiaries may experience coexisting chronic behavioral and psychological conditions, as well as psychosocial challenges. These combined circumstances can significantly affect beneficiaries' quality of life, ability to adhere to medical recommendations and follow care plans; and impact health outcomes.

The MOC encompasses specific D-SNP performance measures, goals, and outcomes, and is incorporated into the overall QI Program. D-SNP specific goals are established based on the analysis and identification of opportunities for improvement within measures and/or processes affecting this population. The QI Program, work plan, and related activities are evaluated annually and reported through Optima Health's committee reporting structure.

4.A.2 Describes specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance.

MOC Quality Objectives

Objective	Responsible Parties	Minimum Frequency of Monitoring
Maintain compliance and coordination with State, Federal, and accreditor regulations to including, but not limited to, Centers for Medicare & Medicaid (CMS), Virginia Department of Medical Assistance Services (DMAS), and National Committee for Quality Assurance (NCQA).	QI, Compliance	Annually
Identify and address demographic and epidemiologic characteristics of the D-SNP membership including those beneficiaries with special needs, severe chronic conditions, and/or those at risk for physical, developmental, behavioral, or emotional conditions.	QI, Care Coordination	Annually
Distribute information to members and providers to improve knowledge about health care safety and improve health outcomes.	QI, Communications	Annually
Provide formal clinical review of member critical incidents/sentinel events to ensure member safety.	QI, Medical Director, Care Coordination	Annually
Assess the availability and accessibility of providers to beneficiaries across a variety of settings and levels of care.	Network Management, QI	Annually
Evaluate the effectiveness of the QI Program and Work Plan and report results to key stakeholders	QI, Quality Improvement Committee	Annually

Computer Systems and Data Collection

Optima Health computer systems, which support quality improvement, are utilized to capture claims, member information, and track care coordination and the utilization management processes. These systems are evaluated by the respective committees/workgroups to determine their effectiveness in assisting quality improvement data collection and processes. All computer systems are HIPAA compliant to comply with privacy laws and professional standards of health information protection.

Optima Health utilizes multiple data sources to assist with the process of continuous analysis and evaluation of MOC performance measures, goals, and other QI activities and initiatives. Data sources that may be utilized are listed below:

- Symphony Care Management System
- claims analysis
- laboratory data
- medical record reviews
- EPIC
- geographic access/availability reports
- membership reports
- quality improvement activities
- pharmacy vendor data
- Inovalon

- Virginia Immunization Registry
- Credentialing reports
- Results of member and provider satisfaction surveys
- EyeMed/VSP
- Member complaints and appeals
- Reports generated by departmental services (e.g., claims lag, telephone abandon rates)

4.A.3 Describes how its leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process.

Ultimate accountability and responsibility for the QI Program rests with the Optima Health Board of Directors (Board), the governing body for Optima Health. The Board is responsible for formulating the Optima Health vision and strategic goals, promoting effective and efficient executive management performance, and promoting quality of member care. The Board's functions as they relate to the QI Program include:

- Annual review and approval of the QI Program Description, annual QI Work Plan, annual QI Evaluation and other reports and information as required;
- Provide feedback and recommendations to the Quality Improvement Committee (QIC) related to summary reports, documents and any issues of concern; and
- Demonstrate senior level commitment to quality and to our QI Program including resource allocation.

The Quality Improvement Committee (QIC) is the decision-making body responsible for the implementation, coordination and integration of all QI activities. The QIC meets at least quarterly and reports to the Board annually, at a minimum. The committee recommends policy decisions, analyzes and evaluates the results of QI activities, institutes actions to address performance deficiencies, and ensures appropriate follow-up, as indicated. The QIC is also responsible for the following:

- Establishment and maintenance of NCQA accreditation for managed care plans,
- Demonstration of quantifiable improvements in care and service,
- Maintenance of a systematic process for the coordination of clinical reviews,
- Monitoring and supporting the implementation of QI programs,
- Coordination of communication of QI activities throughout Optima Health,
- Reviewing and approving the annual QI Program and Work Plan
- Maintaining regulatory compliance related to the QI Program and Work Plan, and
- The oversight and evaluation of QI activities carried out by subcommittees and making necessary recommendations.

The QIC is supported by various committees including:

- Quality Improvement Initiative Committees
- Physician Advisory Council
- Credentialing Committee
- Medical Directors Leadership Committee

- Member Advisory Forums (MAF)
- Community Member Advisory Committee (CMAC)

Quality Improvement Initiative Committees

The various Quality Improvement Initiative Committees were developed to provide interdepartmental leadership and action for measure improvement requiring cross-functional interventions for topics such as Medicare Stars, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program. These committees are responsible for monitoring, measuring, and taking effective action on identified opportunities to improve the quality and safety of service delivery to our beneficiaries.

Physician Advisory Council

The Physician Advisory Council (PAC) has the responsibility to provide a multidisciplinary cohort of community physicians to oversee the Optima Health quality indicators, review policies and procedures related to medical provision of care, and evaluate peer review concerns. The PAC conducts a systematic peer review process that monitors quality and appropriateness of patient care and makes recommendations to the Credentialing Committee as appropriate. As part of this function, the council also reviews and recommends physician education programs. This council is responsible for the development of action plans and recommendations regarding clinical quality improvement studies and service related activities. The PAC approves, reviews, and/or revises clinical guidelines which enhance the delivery of quality of care and appropriate resource utilization, as well as, develops methods for measuring compliance with guidelines as needed.

Credentialing Committee

The Credentialing Committee conducts initial credentialing and re-credentialing of providers who provide care and services to Optima Health beneficiaries. The responsibilities of the Committee include reviewing of provider credentials and making recommendations, reviewing and providing input on Optima Health credentialing policies and procedures, and reviewing committee membership annually to determine adequate spread of specialty and MLTSS representation.

Medical Directors Leadership Committee

The Medical Directors Leadership Committee (MDLC) has the responsibility for evaluating medical and behavioral health procedures for clinical effectiveness, safety, quality, and cost effectiveness. The MDLC evaluates new medical technologies and new uses of existing technology and communicates evidenced based appropriateness of care decisions. The MDLC also reviews and/or revises medical care policies, seeking input from relevant specialists when appropriate.

Member Advisory Forums (MAF)
Optima Health hosts regional member forums to obtain member feedback. The forums are held in the community where the members live and work. D-SNP members are invited and are encouraged to attend these community meetings to provide feedback and ideas to improve the services provided. Each quarterly meeting addresses a specific health issue or Social Determinant of Health and members are given an opportunity to provide feedback on benefits, member experience, and community concerns.

Community Member Advisory Committee (CMAC)
These regional committees consist of members and all community leader types. They convene quarterly to learn about new DMAS and Optima Health initiatives. Participants share ideas on improving health and eliminating the social determinants of health that exist within the underserved community. Additional topics may include, but are not limited to, community relations, benefit changes, new programs, and outreach efforts.

4.A.4 Describes how SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in MOC 4, Element B.

The QI Program drives improvements in both clinical and non-clinical quality, including availability and accessibility of care, service coordination, member and provider satisfaction, and continuity of care. The ultimate goal of our Program is to improve the health outcomes of members by assessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes. The QI Program framework is based on the philosophy of CQI and includes:

- Development of quality improvement initiatives,
- Quality measurement and evaluation,
- Corrective action implementation and evaluation,
- Communication with and education of providers and members, and
- Annual evaluation of the Program's effectiveness.

Optima Health D-SNP QI measures are based on the following four domains:

- Enhanced member experience and engagement for person- and family-centered care,
- Better quality of care and life
- Maintained or improved population health, and
- Reduced per capita costs.

Optima Health conducts an evaluation of the QI Program and Work Plan annually. The evaluation includes reviewing the effectiveness of the previous year's measureable goals,

initiatives, projects and outcomes, as well as, reviewing the appropriateness of the QI Program structure, processes, objectives, and Work Plan. Data is obtained from various sources, and analyzed collectively with the assistance of multiple key departments.

Results of specific D-SNP performance measures, HEDIS® measures, CAHPS® data, Medicare Stars ratings, and other QI activities are reviewed by QIC. Action plans may be created for performance measures that have not met the anticipated benchmarks or thresholds. Results and analysis of the program are also shared with our members and providers.

Optima Health provides any necessary reports of utilization and/or quality improvement in accordance with NCQA standards, CMS regulations, Virginia DMAS and other state regulatory agencies. Scope, submission frequency, and other factors regarding reports change periodically, precluding a complete list.

Evaluation of the Utilization Management Program and Work Plan is presented to the QIC by the Director, Medical Care Management. The results from the annual review of the Utilization Management program and the QIC's commentary are used to improve efforts in the efficient use of resources. The goal is to maximize services that will promote or sustain member health and wellbeing and reduce the number of services that are not considered medically necessary without altering member outcomes.

The Chronic Care Improvement Program (CCIP) aims to improve beneficiary chronic conditions and quality of life over three years with annual updates to CMS. The approved CCIP topic supports CMS's recommended Quality Strategy Goals and targets a chronic condition affecting the D-SNP population. The interventions may include engaging D-SNP members, increasing preventive service utilization and disease management services, identifying and implementing best practices, collaboration with providers, education and outreach, and promoting lifestyle changes.

Other QI initiatives and activities are designed to improve beneficiary/caregiver awareness of conditions affecting the D-SNP population, increase member and provider engagement, improve preventive care rates and enhance beneficiary quality of life including:

- Healthcare Effectiveness Data and Information Set (HEDIS®),
- Health Outcomes Survey (HOS),
- Consumer Assessment Healthcare Providers and Systems (CAHPS®) survey,
- QI critical incident tracking,
- Clinical and nonclinical performance improvement projects, and
- Annually evaluating, reporting, and communicating metrics and goals.

Optima Health conducts performance improvement projects in both clinical and non-clinical areas utilizing the Plan-Do-Study-Act (PDSA) improvement model. Clinical projects are based on prevention and care of acute and chronic conditions, behavioral health, long

term services and supports, high volume services, high risk services and/or high cost services, to improve processes and sustaining change. Non-clinical projects include topics such as measurement and improvement on availability and/or accessibility; cultural competency of services; interpersonal aspects of care; appeals, grievances and complaint; care transition and continuity; coordination of care and care management; and/or member and provider satisfaction. Updates and/or results are submitted to QIC annually, or as defined by the project guidelines.

External Quality Review

Optima Health participates with all External Quality Review Organizations (EQRO) assigned by the Commonwealth of Virginia. Optima Health provides the EQRO with access to required quality information and data. Following the EQRO review, Optima Health provides corrective action plans, as recommended.

Key Personnel Involvement

The Optima Health QI framework necessitates the involvement of several key personnel that is responsible for the internal quality improvement processes and monitoring. The Senior Medical Director of Clinical Integration serves as the QIC chairperson and is responsible for overseeing overall QI Department processes in conjunction with the Director of Quality Improvement. The Quality Improvement Manager leads the QI Department in developing, monitoring, collecting, and reporting of performance measures, and other QI related activities. The QI Department staff is responsible for the daily activities related to collecting, monitoring, and reporting of performance measures and collaborating with key contacts from various departments involved with touchpoints that include D-SNP beneficiaries, such as Care Coordination, Pharmacy, Network Management, Providers, Customer Service, Outreach, Complaints and Appeals, and Credentialing. Representatives from the QI department also serve as members on the QIC and various other committees.

Element B: Measureable Goals & Health Outcomes for the MOC

Factor 4B1: Identify and define the measurable goals and health outcomes used to improve the health care needs of SNP beneficiaries.

Optima Health defines D-SNP measurable goals and health outcomes annually based on industry benchmarks and/or previous performance. Data is collected from various sources including, but not limited to, HEDIS®, Health Outcomes Surveys (HOS), and CAHPS®. Internal reports may include specific care coordination and utilization review metrics, complaints and grievances, condition-specific programs, and credentialing processes. Metrics are reported based on a schedule established by QIC. Reports include quantitative analysis, qualitative analysis, evaluation of barriers, actions taken, and any recommendations for continued improvement.

Communication of Results
Results of the annual Work Plan evaluation and subsequent improvements, as well as metrics, such as HEDIS® and CAHPS® data and Medicare Stars, are communicated in print and electronic formats. Optima Health regularly communicates with stakeholders internally and externally through dashboard reports, website information, newsletters, training materials, and individual mailings, in certain instances. Monthly, a Quality Improvement dashboard is shared internally to depict work done to improve and/or maintain quality. Network Educators provide information on goals and the MOC and evaluation results directly to providers during face-to-face office visits. Internally, metrics and evaluation results are shared with the QIC, the Board, and applicable subcommittees.

4.B.2 Identify specific beneficiary health outcome measures used to measure overall SNP population health outcomes at the plan level.

Optima Health conducts HEDIS® data collection annually. Results are reported to NCQA, CMS, QIC, the Board and other key committees. Results are compared to national benchmarks to identify opportunities for improvement and to establish goals. Additionally, results are shared with the Population Health Workgroup whose membership includes the Senior Medical Director of Clinical Integration, QI Director, QI Managers, Population Care Manager, QI staff and various other key departmental stakeholders who meet regularly and are tasked to discuss goals, benchmarks, current initiatives, corrective actions and opportunities for improvement.

Below are the HEDIS® measures that apply to the D-SNP population for which Optima Health collects and analyzes data:

SNP HEDIS® Measures
Colorectal Cancer Screening
Care for Older Adults
Use of Spirometry Testing in the Assessment & Diagnosis of COPD
Pharmacotherapy of COPD Exacerbation
Controlling High Blood Pressure
Persistence of Beta Blocker Treatment After a Heart Attack
Medication Reconciliation Post-Discharge
Potentially Harmful Drug-Disease Interactions
Use of High Risk Medication in the Elderly
Osteoporosis Management in Older Women
Antidepressant Medication Management
Follow-Up After Hospitalization for Mental Illness
(BCR) Board Certification
Plan All-Cause Readmission

Measurable Goals	**Responsible Department**	**Data Review Frequency**
Focus: Improve coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP, and ICT.		
Timely completion for 100% of HRAs; data collected through Symphony Care Management System	Compliance & Care Coordination	Monthly
Timely completion for 100% of ICPs; data collected through Symphony Care Management System	Compliance & Care Coordination	Monthly
Focus: Ensure appropriate utilization of services for preventive health and chronic conditions.		
Improve Care for Older Adults (baseline and goals to be determined) • Advance Care Planning • Medication Review • Functional Status Assessment • Pain Assessment According to NCQA HEDIS® specifications, Optima Health has not yet established a large enough eligible D-SNP population to gather baseline data. Baseline data collected during the HEDIS® 2020 season, in addition to national benchmarks, will be utilized to establish measurable objectives and goals.	Quality Improvement & Care Coordination	Quarterly

4.B.3. Describe how the SNP establishes methods to assess and track the MOCs impact on SNP beneficiaries' health outcomes.

Optima Health closely monitors measures and projects to ensure goals are met. The QIC quarterly meeting serves as the oversight committee responsible for evaluating, analyzing, and monitoring the various metrics related to process improvement. The Population Health Workgroup discusses topics related to progress and barriers of specific D-SNP measures and takes action where necessary to close identified gaps in processes. Some metrics are monitored on the department level while others are reported on a scheduled basis to QIC or other related committees.

4.B.4. Describe the processes and procedures the SNP will use to determine if health outcome goals are met.

Measurable goals are identified and data reflecting health outcomes are collected, analyzed, evaluated and reported. Each goal has an identified benchmark or threshold based on national standards and/or previous performance. Performance measures will be designated as being met if identified benchmarks or thresholds are achieved. Performance measures may be relayed interdepartmentally or through assigned committees and/or workgroups, including QIC.

4.B.5. Describe the steps the SNP will take if goals are not met in the expected time frame.

When there has been a failure to reach a goal, Optima Health utilizes the Plan, Do, Study, Act (PDSA) method of process improvement to identify gaps and implement changes. A formal action plan including analysis of data, barrier assessments, and interventions or actions planned for improvement may be requested at the discretion of the QIC or other leadership. Other resources to address the failure may include the assignment of a project manager to analyze the process or development of a dedicated workgroup. There will be an expectation for continued reporting to the appropriate committee/workgroup until the goal is achieved and compliance is sustained. Some examples of corrective actions that may be taken to meet goals or strengthen outcomes include:

- Member outreach activities,
- Health Risk Assessment Tool and ICP review and update,
- Member or provider education,
- Policy and/or procedural updates,
- Allocation of staffing or personnel resources,
- Clinical guideline updates,
- Subcommittee or workgroup development, or
- Staff education or coaching.

Element C: Measuring Patient Experience of Care

4.C.1. Describing the specific SNP survey used.
4.C.2. Explaining the rationale for the selection of a specific tool.

Optima Health uses a variety of surveys to measure beneficiary satisfaction and experience of care and conducts all surveys required by CMS. To ensure D-SNP beneficiary satisfaction, Optima Health may leverage Health Outcomes Surveys (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Medicare Health Outcomes Survey (HOS)
The Medicare HOS is a patient-reported outcome measure. An NCQA certified vendor is utilized to administer the survey. The HOS survey was specifically chosen as it collects clinically meaningful, reliable and valid data that can be used to further understand the specific needs of the D-SNP population and thus target service areas that need improvement. The survey is administered annually to a random group or cohort of beneficiaries. Two years later those same respondents will be re-surveyed to identify how well the health plan manages the physical and mental health status and outcomes of its beneficiaries. The HOS is also used to collect four HEDIS® effectiveness of care measures which are: management of urinary incontinence in older adults, physical activity in older adults, fall risk management and osteoporosis testing in older women. Additionally, HOS data is publicly reported by CMS and beneficiaries can use this information to compare health plans.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
The Medicare CAHPS® survey, administered by a CMS certified survey vendor, is used to gain a complete and precise picture of consumer-reported experiences with health care. The survey is administered randomly to a sample of D-SNP beneficiaries or caregivers, should the beneficiary be unable to respond due to special conditions or limitations, using a mixed mail and telephone administration methodology. The survey was chosen because it asks respondents to reflect on member satisfaction regarding health care services which include the following service areas: accessibility of care, continuity of care, quality of care and service, cultural and linguistic concerns, and claims issues. The survey measures how well the health plan is meeting beneficiaries' expectations and is a great tool to identify opportunities for improvement in member satisfaction.

4.C.3. Describe how the results of patient experience surveys are integrated into the overall MOC performance improvement plan.
4.C.4 Describe steps taken by the SNP to address issues identified in survey responses.

Satisfaction survey results will be analyzed and compared to national benchmarks, included as part of the annual QI Work Plan evaluation, and presented to QIC as well as

other various key committees and departments. If performance benchmarks are not met, a corrective action plan and appropriate interventions will be implemented. For example, a special workgroup may be formed to further analyze results and assist with implementations of interventions that may positively impact beneficiaries' health outcomes and experiences of care. QI staff will track opportunities for improvement which will be included on the Work Plan.

QI Critical Incident Tracking

Optima Health critical incident (CI) tracking provides a formal clinical review of unexpected events involving beneficiaries that occur in a nursing facility, inpatient behavioral health, and/or home and community-based service delivery setting. CIs include, but are not limited to, medication errors, severe injury or fall, theft, suspected physical or mental abuse, financial exploitation and unexpected death of a member.

Element D: Ongoing Performance Improvement Evaluation of the MOC

4.D.1 How the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC
4.D.2 How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate the quality
4.D.3 The organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.

4.D.4 How the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

Optima Health is committed to our beneficiaries and to "Improving Health Every Day." We have instituted a continuous quality improvement framework for the MOC to ensure ongoing evaluation of systems, processes, goals, benchmarks, and outcomes that impact our beneficiaries. Performance measures are utilized to support efforts in monitoring and assessing the quality of the program. Under the direction of the Senior Medical Director of Clinical Integration, the Director of Quality Improvement and the QI Manager, QI staff collaborates with key personnel to interpret results of program design evaluation, performance metric data collection, and lessons learned affecting the D-SNP population. The results of the analyses will drive improvements in the MOC framework.

The QIC is responsible for the review and approval of the annual QI Program, Work Plan and Program Evaluation. The QIC utilizes a reporting schedule to ensure timely submission and review of policies and reports. The committee reviews performance reports related to the D-SNP population and weighs in on major operational and clinical drivers such as welcome call monitors, customer service telephone audits, complaints and appeals, credentialing, pharmacy, outreach and education, utilization management, HEDIS® measures, surveys and other reportable indicators that impact quality.

Communication of Results

Results of the annual QI Work Plan evaluation and improvements in the MOC are communicated in print and electronic formats. Optima Health regularly communicates with stakeholders internally and externally through dashboard reports, website information, newsletters, and training materials. Internally, the evaluation results are shared with the QIC and all applicable subcommittees, as well as the Care Coordination staff. Annually, and as modifications and/or improvements to the MOC are made, the results are reviewed by the QIC and cascaded to the other committees, including the Board.

Element E. Dissemination of SNP Quality Performance related to the MOC

4.E.1 Describing how performance results and other pertinent information are shared with multiple stakeholders.
4.E.2 Stating the scheduled frequency of communications with stakeholders.
4.E.3 Describing the methods for ad hoc communication with stakeholders.
4.E.4 Identifying the individuals responsible for communicating performance updates in a timely manner.

The QIC is an essential committee and an integral component of the MOC. It serves as a reporting, advisory, and decision-making committee that provides guidance to subcommittees regarding all areas that impact the quality of care for beneficiaries. The Medical Director of Care Innovations serves as the committee chair and members include representatives from key areas within the organization. The QIC reports directly to the Board of Directors. The QIC meets quarterly, however, *ad hoc* meetings may be scheduled if necessary. Minutes are recorded, reviewed and approved for each meeting. The QIC is also responsible for the review and approval of the annual QI Program, Work Plan and Program Evaluation. In addition to communication via committees, Optima Health communicates any changes and improvements regarding the QI Program through multiple methods including the website and newsletters. The website is updated annually and as necessary to communicate important information to beneficiaries, providers, and other stakeholders. Member and provider newsletters are mailed twice per year.

Beneficiaries may also receive mailed, electronic, or telephonic messages as a reminder to get preventive care or to encourage medication adherence throughout the year. Optima Health makes all information on quality and outcome measures available to CMS, DMAS and NCQA as necessary or requested. QI staff collaborates with various departments including Communications, Network Management, Compliance, and Clinical Care Services to ensure communications are complete, accurate, and timely.

ATTACHMENTS

ATTACHMENT 1

Committees and Reporting Structure Attachments

Sentara Health Plan Board of Directors

The SHP Board of Directors consists of representation from Sentara Health Plans, Inc., Optima Health, Optima Health Group, and Optima Health Insurance Company and is the governing body for all of the health plans. The Board meets quarterly and receives quarterly updates concerning the Quality Improvement (QI) Program from the Chief Medical Officer (CMO) of Optima Health.

Responsibilities

- To review and approve of the annual QI Program, QI Work Plan and QI Evaluation.
- To review regular standardized reports which delineate progress towards implementation of the QI.
- Program, actions taken and improvements made, as well as special studies and follow-up actions.
- To ensure adequate resources and effective implementation of the QI Program.

Membership

Chief Executive Officer (CEO), Sentara Healthcare
President & Chief Operating Officer (COO), Sentara Healthcare
Senior Vice President System Development, Sentara Healthcare
Senior Vice President & Chief Financial Officer (CFO), Sentara Healthcare
Chief Medical Officer (CMO), Sentara Healthcare
CEO Emeritus
General Surgery Physician
Cardiology Physician
Family Practice Physicians (2)
Community Members (2)

Ex officio

Senior Vice President, Sentara Healthcare & President, Optima Health

Meeting frequency

Four times a year

Reporting Responsibility

Reports to the Sentara Board of Healthcare. Formal, dated, and signed minutes documenting the Board's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Optima Health Quality Improvement Committee (QIC)

Responsibilities

- To integrate and coordinate quality improvement into the care and services provided to members throughout the Optima Health medical and behavioral member and practitioner networks.
- To establish processes and structures to maintain the following external accreditations for all accredited lines of business:
  - National Committee for Quality Assurance (NCQA)
  - Managed Care Health Insurance Plan (MCHIP)
- To demonstrate quantifiable improvement in the care and services delivered to members.
- To monitor and support the implementation of the QI program for Optima Health medical and behavioral health plan products.
- To ensure communication of QI activities throughout Optima Health medical and behavioral health products to include, but not limited to our member, provider, employer and broker newsletters.
- To review and approve the annual QI program and work plan.
- To maintain regulatory compliance related to the QI program and work plan.
- To review and approve the annual Clinical Care Services program and work plan.
- To ensure Health Insurance Portability and Accountability Act (HIPPA) policies are established and adhered to for the protection of our members' personal information.
- To review confidentiality policies and practices in the collection, review, use, and disclosure of medical information.
- To maintain a systematic process for the coordination of clinical reviews.
- To oversee and evaluate the quality improvement activities carried out by the following subcommittees: the Physician Advisory Council (PAC), the Compliance Committee, and the Medical Care Review Committee (MCRC) and to make necessary recommendations to those committees as needed.

Membership

President, Optima Health (Ad Hoc)
Chief Medical Officer (CMO), Optima Health
Vice President, Clinical Care Services
Vice President, Analytic Services (Ad Hoc)
Senior Medical Director, Care Innovation
Medical Directors, Clinical Care Services
Medical Director, Behavioral Health
Directors, Clinical Care Services
Director, Analytic Services
Director, Government Programs (Medicaid)

Manager, Complaints & Appeals
Manager, Pharmacy Operations
Manager, Quality Improvement
Manager, Credentialing
Manager, Customer Operations
Manager, Government Programs (Medicare)
Managers, Clinical Care Services
Manager, Network Relations
Manager, Compliance
Coordinators, Quality Improvement
Team Coordinator, Customer Operations
Team Coordinator, Pharmacy Operations
Clinical Pharmacist
Administrative Secretary

Meeting Frequency
Quarterly

Reporting Responsibility
Reports to the Sentara Health Plan Board of Directors. Formal, dated and signed minutes documenting the committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Sentara Healthcare Medical Affairs Committee (MAC)

Responsibilities

- To approve bylaws, policies, rules, regulations, and criteria for the medical staff or relating to medical staff appointments and clinical privileges.
- To take action with regard to medical staff appointment and reappointment including the final approval for credentialing of Sentara Health Plan (SHP) practitioners in Hampton Roads.
- To receive the reports and recommendations from the Medical Staff Executive Committees.
- To serve as the final appeal in the credentialing appeal process for practitioners participating in Hampton Roads and SHP products as designated.

Membership
President & Chief Operating Officer (COO), Sentara Healthcare
Chief Medical Officer (CMO), Sentara Healthcare
Internal Medicine Physician
Cardiology Physician
Urology Physician
General Surgery Physician
Pathology Physician

Radiology Physicians (2)
Community Members (4)

Meeting Frequency

Monthly

Reporting Responsibility

Reports to the Sentara Healthcare Board of Directors. Formal, dated, and signed minutes documenting the committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Optima Health Physician Advisory Council (PAC)

Responsibilities

- To conduct a peer process review that provides a systematic approach for monitoring of quality and appropriateness of patient care.
- To review referred cases and recommend actions for peer review to the Credentialing Committee.
- To support the development of action plans and recommendations regarding clinical quality improvement studies and service related activities.
- To assess, review, approve, and/or revise clinical guidelines to enhance the delivery of quality of care and appropriate resource utilization. Develop methods for measuring compliance with guidelines as needed.
- To collaborate with the Quality Improvement team to evaluate the effectiveness of proposed HEDIS improvement initiatives for mandatory HEDIS performance measures for compliance and overall improvement of HEDIS scores.
- To review and recommend physician education programs as needed.
- To review various committee minutes including Medical Care Review Committee (MCRC), Pharmacy and Therapeutics (P&T) Committee, and Medical Directors Leadership Committee (MDLC) and provide consultative advice, input and support as needed.

Membership

Family Practice
Pediatrics (2)
Family Medicine
Internal Medicine
Obstetrics/Gynecology
Behavioral Health
Optima Health President
Optima Health Chief Medical Officer
Optima Health Vice President Clinical Services
Optima Health Medical Director
Optima Health Medical Director
Optima Health Director of Pharmacy

Meeting Frequency
Meets every other month and as needed

Reporting Responsibility
Reports to the Sentara Health Plan Board of Directors. The PAC provides communication to the Quality Improvement Committee (QIC) regarding clinical guidelines, safety programs, and physician-related service components. The PAC also communicates and refers cases to the Credentialing Committee as is deemed appropriate. Formal, dated, and signed minutes documenting the committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Optima Health Compliance Committee

Responsibilities
- To provide oversight of the Optima Health Compliance Program and assure all Optima Health personnel and resources are available to the operation of the Compliance Program.
- To promote a culture of compliance with Optima Health.
- To communicate a compliance vision and business direction that advances compliance initiatives.
- To review and analyze laws and regulations, industry environment, fraud alerts, product contracts and risk areas.
- To monitor compliance program development, implementation and operations on an on-going basis.
- To determine a strategy to promote compliance, solicit reports of potential complaints and problems and detect potential violations.
- To analyze the Optima Health managed care environment, the specific legal risk requirements with which Optima Health must comply and evaluate specific risk areas.
- To establish policies and procedures, standards of compliance and measurement tools that address legal requirements and risk areas.
- To evaluate compliance program descriptions, work plans, and evaluations at least annually.
- To recommend and monitor the development of internal systems and controls to monitor and audit compliance standards.
- To maintain systems to solicit, evaluate and respond to complaints and problems.
- To coordinate with the Corporate Compliance program and policies as required.
- To oversee the implementation of corrective action plans as necessary.
- To evaluate the effectiveness of employee training and education.
- To evaluate the effectiveness of the Compliance Program.

- To create and review confidentiality and Health Insurance Portability and Accountability Act (HIPAA) policies and review practices in the collection, use, and disclosure of medical information.

Membership

Vice President, Customer Operations
Vice President, Clinical Care Services
Vice President, Managed Long Term Services & Support
Vice President & Chief Actuary
Vice President & Controller
Assistant General Counsel
Director, Compliance
Director, Government Programs (Medicare)
Directory, Pharmacy
Director, Accounting
Director, Human Resources
Manager, Compliance Audit, Sentara Healthcare
Managers, Compliance
Manager, Quality Improvement
Manager, Business & System Integration
Manager, Accounting
Manager, Network Relations
Director, Sales Operations

Ex Officio

President, Optima Health
Vice President, Government Programs & Compliance

Meeting Frequency

Quarterly

Reporting Responsibility

Reports an annual summary of Compliance Committee minutes to the Quality Improvement Committee (QIC). Formal, dated, and signed minutes documenting the Committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Optima Health Credentialing Committee

Responsibilities

- To credential and re-credential practitioners according to established policies and procedures.
- To conduct a review of all practitioners who apply for participation in the

Optima Health Plan (OHP) and Optima Behavioral Health (OBH) plans.

- To review all participating practitioners for re-credentialing purposes, including the review of any clinical or service quality issues or utilization data/reports. (This does not include economic credentialing)
- To recommend approval or denial for practitioner participation in OHP plans to the Medical Affairs Committee.
- To serve as the final approval body for non-Hampton Roads practitioners.
- To review and update credentialing policies and procedures.
- To recommend physician sanctions to the Physician Advisory Council (PAC) based upon re-credentialing data/information.
- To provide delegation oversight for OHP and OBH delegation agreements.
- To ensure that all voting members of the OHP Credentials Committee are network providers and not employees.

Membership

General Surgery Physician
Family Practice Physician
Obstetrics and Gynecology Physician
Cardiology Physician
Pulmonary Physician
Pediatric Physician
Medical Directors
Manager, Credentialing
Analysts, Credentialing

Meeting Frequency

Monthly

Reporting Responsibility

Reports to the Medical Affairs Committee (MAC). Formal, dated, and signed minutes documenting the committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Optima Health Behavioral Health Credentialing Committee

Responsibilities

- To credential and re-credential practitioners according to established policies and procedures.
- To conduct a review of all practitioners who apply for participation in the Optima Behavioral Health (OBH) plans.
- To review all participating practitioners for re-credentialing purposes, including the review of any clinical or service quality issues or utilization data/reports. (This does not include economic credentialing)
- To recommend approval or denial for practitioner participation in OBH plans to the

Medical Affairs Committee (MAC) for Hampton Roads and to the OHP Credentials Committee for non-Hampton Roads practitioners.

- To serve as is the recommended approval body for community health practitioners.
- To recommend approval or denial for all practitioner applications.
- To review and update all credentialing policies and procedures.
- To recommend practitioner sanctions to the Medical Care Review Committee (MCRC) based upon re-credentialing data/information.
- To provide delegation oversight for OBH delegation agreements.
- To ensure that all voting members of the OBH Credentials Committee are network practitioners and not employees.

Membership

Psychiatrists (2)
Licensed Clinical Social Worker (LCSW)
Psychologist
Licensed Professional Counselor
Clinical Nurse Specialist
Medical Directors (2)
Manager, Credentialing
Analysts, Credentialing (4)

Meeting Frequency

Monthly

Reporting Responsibility

Reports to the OHP Credentialing Committee for Central Virginia practitioners and the Medical Affairs Committee (MAC) for Hampton Roads practitioners. Formal, dated, and signed minutes documenting the committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Optima Health Medical Care Review Committee (MCRC)

Responsibilities

- To monitor the quality of care provided to members, identify and advise Optima Health of behavioral health practitioner educational needs to address quality issues.
- To conduct a review process that provides a systematic approach for monitoring of quality and appropriateness of behavioral health care for members.
- To review the proposed clinical guidelines and make recommendations to the QIC.
- To review individual cases for clinical quality of care concerns and recommend improvement activity to the Behavioral Health Medical Director and QIC.
- To review member satisfaction information and provide improvement plan recommendations to the QIC.
- To review Quality Improvement activity results and provide recommendations to

QIC.

- To review new technology developments relevant to behavioral health, including psychotropic medications and make recommendations to the Pharmacy & Therapeutics (P&T) Committee and QIC.
- To conduct a peer review of behavioral healthcare practitioners.
- To recommend improvements in behavioral health clinical care and services to the QIC.
- To utilize ongoing peer review to monitor practice patterns to clarify the appropriateness of behavioral healthcare and areas for improvement/risk prevention.
- To recommend to the QIC clinical protocols/guidelines.
- To review clinical study designs and results.
- To develop improvement plans and recommendations regarding clinical quality improvement studies.

Membership

Community Psychiatrists (4)
Community Licensed Clinical Social Worker (LCSW)
Community Clinical Psychologist
Behavioral Health Medical Director
Coordinator, Quality Improvement

Meeting Frequency

Every other month

Reporting Responsibility

Reports to the QIC, PAC and Plan committees as appropriate. Formal, dated, and signed minutes documenting the Committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Optima Health Medical Directors Leadership Committee (MDLC)

Responsibilities

- To evaluate the safety, clinical and cost-effectiveness of diagnostic and therapeutic therapies, interventions and technologies that will continue to allow Health Plan members access to safe and effective evidenced-based care.
- To assist the Health Plan in making coverage decisions regarding all relevant medical, behavioral health, pharmaceutical and device-related aspects of care.
- To improve the efficiency and quality of decision making at the meetings by developing and instituting a continuous process improvement plan.
- To improve communication among departments regarding policy/procedure changes.
- To evaluate new and existing medical technologies and relevant policies and to communicate the evidenced-based appropriateness of care decisions

every month or as needed to the Optima Health Benefit and Policy Committee.
- To seek input from relevant specialists when appropriate and provide copies of the MDLC minutes to the Physician Advisory Council (PAC) for review and approval.

Membership
Chief Medical Officer Medical Directors
Behavioral Health Medical Director
Community Physician, Internal Medicine
Director, Clinical Care Services
Director, Network Management
Director, Pharmacy
Manager, Clinical Care Services
Manager, Clinical Claims Review
Manager, Appeals
Manager, Education, Clinical Care Services
Sr. Business Analyst
Sr. Healthcare Economics Consultant
Fraud & Abuse Investigator
Clinical Pharmacist
Coordinator, Technology Review
Administrative Secretary

Ex Officio
President, Optima Health
Vice President, Clinical Care Services

Meeting Schedule
The second and fourth Tuesday of each month.

Reporting Responsibility
Reports to the Optima Health Executive Council. Formal, dated, and signed minutes documenting the Committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

Pharmacy and Therapeutics Committee (P&T)

Responsibilities
- To systematically monitor and evaluate the appropriateness and effectiveness of drug utilization by evaluating against pre-established clinical indicators.
- To serve as an educational resource on quality matters.
- To maintain the Optima Health formulary.
- To conduct drug utilization evaluation studies based on demographic, epidemiologic information and to review the results and implement corrective

action plans for identified problems.
- To evaluate pre-authorization process data continuingly.
- To identify mechanisms to increase generic market share where appropriate.
- To provide education to physicians and other health care professionals on formulary information.

Membership

Family Practice Physicians
Internal Medicine Physicians
Pediatric Physicians
Geriatrics Physician
Psychiatrist
Chief Medical Officer (CMO)
Vice President of Pharmacy, Sentara Healthcare
Medical Directors
Director, Pharmacy
Clinical Pharmacy Specialist
Clinical Pharmacists
Community Pharmacist

Meeting Schedule

Monthly

Reporting Responsibility

Reports to the Physician Advisory Council (PAC). Formal, dated, and signed minutes documenting the Committee's activities, decisions, findings, and recommendations are maintained for each meeting. The minutes are available for review at the request of any regulatory or accrediting body.

ATTACHMENT 2

Medicare Dual-Eligible Special Needs Plan (D-SNP) Quality Improvement Annual Work Plan

Purpose and Scope

The Quality Improvement (QI) Work Plan provides a schedule of activities directed toward organizational objectives, and goals required to implement the Quality Improvement Program. This Work Plan addresses QI goals and initiatives that target the special needs, complex conditions, and challenges faced by D-SNP beneficiaries. The Work Plan also includes a reporting tracking mechanism, the Reporting Grid which contains information about departmental responsibilities regarding deliverables and timeframes. Close monitoring of reporting timeframes and deliverables will ensure Optima can deliver timely high-quality health care services to its members. Member safety is a priority consideration in the development and implementation of all activities.

Quality Improvement Activities

Optima Health implements ongoing QI initiatives that may improve specific performance measures, and impact beneficiaries' health outcomes. For example, to increase preventive health screenings, beneficiaries are sent a birthday card with reminders about screenings.

General Initiatives
Member Communication
Identify eligible members with specific conditions
Patient education materials sent to members with a new diagnosis of specific conditions (Diabetes, Hypertension, Asthma (***Live Better with Diabetes*** booklet), letter to encourage retinal eye exam, HgbA1c, LDL, microalbumin urine testing, smoking cessation, exercise, appropriate use of medications
Utilize electronic telephonic messages to deliver educational information, exam screening and medication adherence reminders (diabetes, cardiovascular, antipsychotic medication adherence, Persistent Medications, Well Child, ADHD education, Asthma trigger avoidance
Member newsletter articles of select topics
Explore wellness incentives
Send Birthday cards to members with a reminder regarding specific screenings (mammogram, cervical, preventive
Send physician and non-compliant member reminder letters for regarding specific screenings (mammogram, breast cancer screenings, pneumococcal,
Collect supplemental data from EPIC for specific measures (colorectal,
Record results from monthly reminder letters and review charts for exclusions (i.e. TVH or TAH) and enters in the supplemental database
Collect data on labs (Glucose, HgA1c, LDL-C) done during inpatient hospitalization for

General Initiatives
Member Communication
members with diagnosis of Schizophrenia/Bipolar Disorder
Direct mailings to members about the importance of annual screenings for select measures (colorectal)
Offer culturally competent educational materials via the Optima website
Update content on Optima Website/Member Newsletter/ Health & Wellness screenings
Screen members with chronic medical conditions for depression using PHQ-9 by 3rd telephonic contact (performed by Case Managers)
Educational information/reminders inserted on calendars distributed to members (Flu, Pneumococcal)
Maintain pertinent health-related information on the Optima Health Website
Provider Communication
Provider newsletter articles on select topics
Update Guidelines and notify physicians
Letter and list of diabetes members that includes most recent diabetes-related exams and test results if available
Provider education (information provided by Network Management)
Linking practitioners
Provide preventive healthcare information to providers on the Optima Health website
Educational Opportunities
Educational in-service for staff provided by the CCS Team
Linking practitioners, case managers and nurses to web-based CME/CE activities on culturally competent care

ATTACHMENT 3

Benefit Enhancements for CY2020

To support the goals of the Model of Care, the following enhancements have been made to Optima Community Complete's plan benefit package for CY2020:

- Acupuncture – 15 visits per year (new)
- Annual physical exam – 1 visit per year (new)
- Preventive dental (new)
  - Cleanings – 2 per year
  - Oral exams – 2 per year
  - X-rays – 2 per year
  - Fluoride treatments – 2 per year
- Routine eye exams – 1 per year (new)
- Vision allowance for eyewear - $200 per year (new)
- Over-the-counter (OTC) product allowance - $100 per quarter (new)
- Routine foot care – 6 visits per year (new)
- Post-discharge meals – up to 56 meals (2 a day for 28 days) following discharge from an inpatient facility (new)
- Therapeutic massage for pain management – 15 visits per year (new)
- Transportation – 24 one-way trips per year to primarily health-related locations, such as the doctor's office or a pharmacy (new)
- Transportation, Special Supplemental Benefits for Chronically Ill (SSBCI) – 24 one-way trips per year to non-primarily health-related locations, such as church, beauty salon, grocery store, etc. (new)